THE MEDICARE VALUE-BASED PURCHASING FOR PHYSICIANS ACT

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES

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THE MEDICARE VALUE-BASED PURCHASING FOR PHYSICIANS ACT

THURSDAY, SEPTEMBER 29, 2005

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HEALTH
Washington, DC.

The Subcommittee met, pursuant to notice, at 3:00 p.m., in room 1100, Longworth House Office Building, Hon. Nancy L. Johnson (Chairman of the Subcommittee) presiding.

[The advisory announcing the hearing follows:]

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON HEALTH

FOR IMMEDIATE RELEASE
September 22, 2005
No. HL–9

CONTACT: (202) 225–3943

Johnson Announces Hearing on the Medicare Value-Based Purchasing for Physicians Act

Congresswoman Nancy L. Johnson (R–CT), Chairman, Subcommittee on Health of the Committee on Ways and Means, today announced that the Subcommittee will hold a hearing on H.R. 3617, the "Medicare Value-Based Purchasing for Physicians' Services Act of 2005." The hearing will take place on Thursday, September 29, 2005, in the main Committee hearing room, 1100 Longworth House Office Building, beginning at 3:00 p.m., or immediately following the full Committee hearing.

In view of the limited time available to hear witnesses, oral testimony at this hearing will be from invited witnesses only. However, any individual or organization not scheduled for an oral appearance may submit a written statement for consideration by the Committee and for inclusion in the printed record of the hearing.

BACKGROUND:

H.R. 3617, introduced by Congresswoman Johnson on July 29, 2005, would repeal the Sustainable Growth Rate formula and replace it with a stable and predictable annual update based on changes in the costs of providing care. Such payments would be linked to health care quality and efficiency.

This legislation would provide a differential payment update to practitioners meeting pre-established thresholds of quality or pre-established levels of improvement, equal to the Medicare Economic Index (MEI). Practitioners not meeting these thresholds would receive an update of MEI, minus 1 percent.

Measures of quality and efficiency would include a mix of outcome, process and structural measures. Clinical care measures must be evidence-based. Practitioners would be directly involved in determining the measures used for assessing their performance.

The Centers for Medicare & Medicaid Services would be required to analyze volume and spending growth annually, and make recommendations on regulatory or legislative changes to respond to inappropriate growth. The Medicare Payment Advisory Commission would review this report and recommendations.

In announcing the hearing, Chairman Johnson stated, "I introduced the Medicare Value-Based Purchasing Act in response to testimony at our three Subcommittee hearings on physician payments and value-based purchasing this year. Many of my colleagues on this Subcommittee and in the House support this bill, and I thank them for that support. For several years, I have argued that the current Medicare payment system for physicians is unsustainable. I believe that this legislation represents an important step in our efforts to move Medicare into the twenty-first century. We have the ability to vary payment based on the quality and efficiency of care delivered to our seniors under Medicare, and we should use it. This hearing will offer the Subcommittee an opportunity to hear from witnesses about this important legislation."

FOCUS OF THE HEARING:

The hearing will focus on the provisions in H.R. 3617.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Please Note: Any person(s) and/or organization(s) wishing to submit for the hearing record must follow the appropriate link on the hearing page of the Committee website and complete the informational forms. From the Committee homepage, *http://waysandmeans.house.gov,* select "*109th Congress*" from the menu entitled, "*Hearing Archives*" (*http://waysandmeans.house.gov/Hearings.asp?congress=17*). Select the hearing for which you would like to submit, and click on the link entitled, "*Click here to provide a submission for the record.*" Once you have followed the online instructions, completing all informational forms and clicking "submit" on the final page, an email will be sent to the address which you supply confirming your interest in providing a submission for the record. You ***MUST REPLY*** to the email and ***ATTACH*** your submission as a Word or WordPerfect document, in compliance with the formatting requirements listed below, by close of business Thursday, October 13, 2005. **Finally,** please note that due to the change in House mail policy, the U.S. Capitol Police will refuse sealed-package deliveries to all House Office Buildings. For questions, or if you encounter technical problems, please call (202) 225–1721.

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The Committee relies on electronic submissions for printing the official hearing record. As always, submissions will be included in the record according to the discretion of the Committee. The Committee will not alter the content of your submission, but we reserve the right to format it according to our guidelines. Any submission provided to the Committee by a witness, any supplementary materials submitted for the printed record, and any written comments in response to a request for written comments must conform to the guidelines listed below. Any submission or supplementary item not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All submissions and supplementary materials must be provided in Word or WordPerfect format and MUST NOT exceed a total of 10 pages, including attachments. Witnesses and submitters are advised that the Committee relies on electronic submissions for printing the official hearing record.

2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.

3. All submissions must include a list of all clients, persons, and/or organizations on whose behalf the witness appears. A supplemental sheet must accompany each submission listing the name, company, address, telephone and fax numbers of each witness.

Note: All Committee advisories and news releases are available on the World Wide Web at *http://waysandmeans.house.gov*.

The Committee seeks to make its facilities accessible to persons with disabilities. If you are in need of special accommodations, please call 202–225–1721 or 202–226–3411 TTD/TTY in advance of the event (four business days notice is requested). Questions with regard to special accommodation needs in general (including availability of Committee materials in alternative formats) may be directed to the Committee as noted above.

Chairman JOHNSON. Good afternoon, everyone. I am going to call the hearing to order. Pete is on his way, but I am going to start with my opening statement, assuming that he will survive not hearing it. We are going to have five votes in an hour, so we are going to try to hear all of our witnesses before we do have to vote because it is such a long recess, and after that, of course, people

are flying off to planes. Let me just open by saying I am very pleased to be holding this hearing on actually a legislative initiative that we introduced and a series of amendments that we have circulated. I want to thank many of my colleagues on the Subcommittee for cosponsoring the legislation and for many others for taking an intense interest in it, because I think this initiative represents an attempt to move into the 21st century. It is not going to be perfect, but it is a serious start. There are 80 pay-for-performance systems out there already, and I think it is very important that the Federal Government set a model of how you do this and try to make sure that as the Nation moves in this development—in this direction, there is some homogeneity in both process and criteria.

Today's legislative hearing on H.R. 3617 follows a series of hearings by this Subcommittee to explore ways to address physician reimbursement under the Medicare Program. This legislation incorporates the many ideas brought to the Subcommittee by government agencies, physician and other practitioner organizations, purchasers with experience in value-based purchasing in the private market, and representatives of Medicare beneficiaries. To promote health care quality, as well as efficiency in Medicare, the bill would no longer pay providers the same amount regardless of the quality of the care they provide. Payment updates would be linked to health care quality and efficiency. Under this legislation, Medicare would provide a differential update for physician services. All practitioners would receive a 1.5-percent update in 2006 instead of the 4.4-percent decrease projected under the current law, and in 2007 and thereafter—2007, 2008, practitioners who report quality and efficiency measures would receive an update equal to the medical economic index (MEI). Those who do not report will receive a lower but still positive update equal to the MEI minus 1 percentage point. This is similar to how we currently pay hospitals under Medicare.

Beginning in 2009, practitioners who meet pre-established thresholds of quality or show pre-established levels of improvement would receive a payment update equal to the MEI. Those who do not meet this threshold would receive a positive but lower update equal to MEI minus 1 percentage point. The legislation provides a structure for a value-based program. It outlines characteristics that quality measures must satisfy. For example, measures must include a mix of outcome, process and structural measures; be evidence-based if they are related to clinical care; be consistent, valid, practical and not overly burdensome to collect. So, there are a number of criteria in the bill that measures must meet to assure that they are objective and quality-oriented. The program must address issues of fairness by adjusting measures and ratings to account for very sick patients, those who cannot or do not comply with directives or who are located in neighborhoods where traditions delay entry into the health care system. It is critically important that the value-based program not encourage patient selection or de-selection. The legislation outlines a process for selecting measures that ensures that practitioners would be directly involved in the measures used to gauge their performance.

Practitioners would submit clinical care—I am going to cut short my opening statement and not go through the whole process. It is laid out in the bill. But I do want to note that I believe it is terribly important that clinicians have control over clinical measures. So, in the bill, they do make the proposals, and while the consensus-building body builds consensus around which measures are most important to use, the government actually cannot invent clinical measures. The government can initiate on its own process and structural measures and goes through the rulemaking process to assure that they receive public input in the process of identifying measures in those categories.

Our witnesses provide their thoughts on this legislation and on the amendments that we have circulated. On our first panel we have Dr. Mark McClellan, the Centers for Medicare and Medicaid Services (CMS) Administrator. Our second panel includes Dr. Robert Berenson of the Urban Institute and a former CMS official who brings us a wealth of knowledge about physician payments. Dr. Thomas Jevon is a family physician in solo practice located in Wakefield, Massachusetts, who will provide input from that perspective. Dr. Jevon also will share his experiences with the Bridges to Excellence quality improvement program as a solo practitioner. Karen Ignagni, from America's Health Insurance Plans, will provide us with a purchaser's point of view and give us examples of value-based purchasing programs from her member companies. Our last witness, Dr. John Armstrong from the American Medical Association (AMA), will present the views of physicians of the AMA, many of which have had experience with physician payment systems similar to that recommended in the legislation. Mr. Stark, welcome, and would you like to make an opening statement?

Mr. STARK. I would love to. Thank you, Madam Chair. This is our fourth hearing this year on this physician payment system or problem, and we still haven't focused in on the underlying issues that got us to where we are today. The administration, majority, organized medicine and, I suppose, us by acquiescence all know full well what the temporary increases in the Medicare Modernization Act (MMA), would exacerbate the cliff or the drop that we now face, yet we have done nothing to craft a solution. We have had a lot of hearings, but no solutions. Organized medicine and many in Congress have proposed to just repeal the sustainable growth rate (SGR) with little or no discussion or options as to what we could replace it with. I am not going to defend the SGR, but—I will let Chairman Thomas do that—but in my view, simply repealing it isn't an option. I think you told us, Dr. McClellan, sometime in previous testimony that we are talking $180 billion to do it, and that is a little scarce right now. People are quite enchanted, if not overly focused, on the this notion of pay for performance. Done properly, that would show me some promise. But I don't believe it can be done without a decent information technology plan in place.

I would be willing to look, but I just don't—I think that particular issue—and I don't think until we are able to have complete electronic recordkeeping and universal recordkeeping that we can track pay for performance. Even then I suspect it would take several years, if not 10, to get the whole system going. I think the best thing we have now are the demonstrations that CMS has for hos-

pitals and physicians, and I think we could watch those and evaluate those and have a better idea then of how to expand from the demonstrations that are now going forth. To rush to embrace this, is a fad as I call it, has diverted our attention from underlying problems in physician reimbursement, a system that needs to have these problems addressed; RBS utilization, Committee process, coding issues, perverse incentives, a whole host of things that I think we have to straighten out. The critical component of fee-for-service Medicare has been ignored. The current system allows abusive providers to profit while the prudent providers pay the price in terms of reduced fees. We have to keep in mind that physician increases lead to premium increases unless we prevent it. Our beneficiaries are going to have record high increases, the next year increase again significant. We need to protect these premiums, and I share AARP's stand on this.

I want to remind everyone—and although I would not be so skeptical as to suggest it was intentional—increased physician spending will get us very quickly toward this arbitrary 45-percent cap on Medicare's general revenue support. That to me is the sword of Damocles hanging over our head, and if that drops, we are in the soup. That, in effect, destroys Medicare as we know it. If that is the intention of the administration and the majority, fine, let's talk about it; but the idea that we hit the 45-percent cap and then we no longer have an entitlement to me is something that I think should be repealed or else addressed with some replacement for Medicare as an entitlement. I would be willing to, as I discussed with the Chair and with Dr. McClellan, to support—whether you care whether I support it or not—but I would be willing to negotiate to support some kind of a 2-year override in the plan cuts, provided that we have some concrete steps for a new mechanism, whether it is geographic or specialty-specific targets, that would keep some control on overall expenditures. The best way, of course, to pay for this all would be to bring the plan payment down to fee-for-service rates, which is what we always intended, and nobody has ever shown me that the plans deserve this outrageous bonus that they are getting. In the meantime, I would support starting with pay for performance in the private plans. Let us start with these plans as MedPAC has recommended. They already have the data. They claim they deliver high-quality care. Let us hold them accountable, and, as they say, let us see if they can walk the walk as well as they talk the talk. Thanks.

Chairman JOHNSON. Thank you very much, Pete. I would like to just acknowledge the presence of two of the Republican physicians who have been very actively interested in the health care legislation that we have been working on, Dr. Burgess of Texas and Dr. Gingrey of Georgia. Welcome to sitting with us this afternoon. All of the issues that Pete raised will be a part of our discussion as we move forward. There are two sides to every matter, and I hope that we can come to an understanding that allows my colleague from California to work with me on this legislation, because I certainly respect his concerns. Dr. McClellan.

STATEMENT OF THE HONORABLE MARK MCCLELLAN, M.D., PH.D., ADMINISTRATOR, CENTERS FOR MEDICARE AND MEDICAID SERVICES, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Dr. MCCLELLAN. Madam Chairman, Congressman Stark, distinguished Subcommittee Members and other distinguished Members, thank you for the opportunities to be with you here this afternoon. In recent weeks we have seen once again the critical role that physicians play in helping people recover and stay well. We saw this in the response to Hurricane Katrina where when evacuees needed care all through the gulf coast and around the country, local physicians did not ask, how is this going to be paid for, what are the rules? They asked, what kind of care and assistance do evacuees need? They started providing it. We responded by supporting those efforts through modifications in our rules in Medicare and Medicaid and setting up a new waiver program that is already now available to most evacuees in our payment systems. In addition, I want to thank the physician community for being one of our most critical partners as we work to bring new drug coverage to Medicare beneficiaries on schedule and nationwide. Physician organizations and physicians all over the country have taken steps, like making available brochures and other information on where their patients can get the support they need to take advantage of the new coverage.

On average, seniors are going to see their out-of-pocket costs fall by many hundreds of dollars next year, and I truly appreciate the effort physicians are taking to ensure that their patients have access to the medicines they need in this new program. As you well know, physician participation and leadership are also critical in providing care to beneficiaries in Medicare. We need to ensure that physicians are adequately compensated for this care in the Medicare Program, but how we pay also matters. Medicare's payment system for physicians should be set up to encourage and support them in providing quality care and preventing avoidable health care costs. After all, physicians are in the best position to know what can work best to improve their practice. Updates in the current payment system for physician services are now projected to be negative for the next 7 years. Continued negative updates for many years are not sustainable in terms of assuring access to quality care for Medicare beneficiaries. At the same time, simply increasing spending by adding larger updates into the current payment system is also not sustainable from the standpoint of Medicare's costs or beneficiary premiums and cost sharing, so it is critical now for Medicare to support physicians in achieving better care for our beneficiaries at a lower overall cost.

I would like to thank you, Madam Chairman, for your leadership on this issue. I would like to thank the Ranking Member for his continued efforts to make sure that Medicare and our beneficiaries are getting the most value. There is also bipartisan interest in the Senate. We intend to continue working closely with you to consider changes to increase the effectiveness of how Medicare compensates physicians and to take new steps to avoid unnecessary costs. That is the best path to a sustainable payment system. I also want to thank the Nation's physician organizations for their leadership on

issues of quality and performance. Thanks in part to the leadership and hard work of many physician organizations, substantial progress has been made to develop quality measures for most physician specialties. In fact, they have identified 66 evidence-based quality measures for 29 specialties, as I detail in my written testimony. Those specialties represent 80 percent of Medicare physician spending. This is tremendous progress working together, and physician leadership has helped make it possible. We are also developing the infrastructure needed to support the reporting of measures like these on existing physician claims as soon as 2006. While we are still analyzing the issues, we are working out the details so that voluntary reporting can be accomplished under existing statutory authorities.

Our collaborative work on identifying and measuring quality care so that we can better support it has been guided by some widely accepted principles. Quality measures should be evidence-based, valid, reliable and relevant to a significant part of a physician's actual practice. It is always important that quality measures do not discourage physicians from treating high-risk or difficult cases, as you mentioned. In addition, quality measures should be implemented in a realistic manner that is most relevant for quality improvements in all types of practices and patient populations while being least burdensome for physicians and other stakeholders. To make sure that these principles are met, quality measures should be developed in conjunction with open and transparent processes that promote consensus from a broad range of health care stakeholders.

To achieve these goals, CMS joined in a process with the National Committee of Quality Assurance (NCQA), the AMA's Physician Consortium For Performance Improvement, other physician organizations and stakeholders to develop measures that would be appropriate for the ambulatory setting. We supported the National Quality Forum (NQF) endorsement of ambulatory care measures developed by the NCQA and the Physician Consortium. More recently we have also been working with the Ambulatory Care Quality Alliance, the American College of Physicians, the American Academy of Family Practitioners, the Nation's health plans and many other stakeholders to expand these efforts, and we are building on this progress—that I have already noted—with additional primary care quality measures as well as measures in other specialties. Activity is under way to prepare the other measures for NQF endorsement. As a result of this activity, we have 66 measures, as I mentioned, and 30 have already been endorsed or a part of the NQF process.

The bottom line is that quality measures or indicators have been developed or are well along in the development process for most physician specialties. There are strong collaborations among health care providers and other stakeholders to build on this rapid progress to improve quality and avoid unnecessary costs. This is very good news for achieving our shared goal of supporting the best efforts of physicians to keep seniors well and to keep health care costs down. Madam Chairman, Mr. Stark, thanks again for the opportunity to testify. I would be happy to answer any of your questions.

[The prepared statement of Dr. McClellan follows:]

Statement of The Honorable Mark McClellan, M.D., Ph.D., Administrator, Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services

Madam Chairman Johnson, Congressman Stark, distinguished Subcommittee members, thank you for inviting me to testify on value-based purchasing for physicians under Medicare.

I want to take this opportunity to thank the physician community for their heroic efforts on behalf of evacuees of hurricanes Katrina and Rita. Physicians rushed to provide care for those in need without even considering payments or program requirements. Providers who were personally affected by the hurricanes as well as those in areas sheltering evacuees have provided extensive medical services under the most challenging conditions. We have acted expeditiously to provide effective support for these efforts. We've done this through administrative adjustments to our Medicare and Medicaid payment rules. And we've implemented a new Medicaid waiver that provides for immediate, temporary Medicaid coverage as well as financial support for needed medical services that fall outside of standard Medicaid benefits, all using existing systems in the affected states so that they can be implemented quickly and effectively. Within just ten business days CMS reviewed and approved waivers for the states housing the vast majority of evacuees, including Texas, Arkansas, Mississippi, Alabama, Georgia, Florida, Idaho, and the District of Columbia. And we are working closely with all other states that need financial support. Through these efforts, we are helping all evacuees get the care they need as they get back on their feet, we are making sure that the health care providers get reimbursed for providing that care, and we are making sure that the states hosting the evacuees are covered for any substantial expenses that they incur.

In addition, the physician community is one of our key partners as we work to implement the Medicare Modernization Act (MMA). As you well know, we are rapidly approaching the implementation date for Medicare's new prescription drug coverage. As physicians have known for many years, adequate access to medications is more important today than ever before. Physician organizations have worked closely with us to help inform their membership about the new benefits coming in Medicare to help their patients get access to up to date care. Physicians all over the country are helping beneficiaries take advantage of the new coverage, for example by providing materials in their offices about the basics of Medicare's prescription drug coverage, and letting them know where to go to get the information and support they need to make a confident decision. The new Medicare drug coverage will be available on time, nationwide, at a lower cost and with more benefits available than many people had expected. As a result, on average seniors will save many hundreds of dollars next year in their total out of pocket costs. I truly appreciate the time and effort physicians are taking to ensure their Medicare patients have access to the medications they need.

As I testified in July, continued improvement of the Medicare program requires the successful participation of physicians and we need to ensure they are adequately compensated for the care they provide to people with Medicare. But how we pay also matters. In addition to providing adequate payments, Medicare's payment system for physicians should encourage and support them to provide quality care and prevent avoidable health care costs. After all, physicians are in the best position to know what can work best to improve their practices, and physician expertise coupled with their strong professional commitment to quality means that any solution to the problems of health care quality and affordability must involve physician leadership.

Updates to the current payment system for physicians' services are projected to be negative for the next seven years. Such continued negative updates raise real concerns about this payment system in terms of assuring access to quality care for Medicare beneficiaries. At the same time, simply increasing spending by adding larger updates into the current volume-based payment system that is already experiencing increases of 12 to 13 percent or more per year would have an adverse effect from the standpoint of Medicare's finances or beneficiary premiums and cost-sharing, and does not promote better quality care.

However, it is clear, under our current system, there is much potential for physicians to improve the value of our health care spending. Under the current system, there are substantial variations in resources and in spending growth for the same medical condition in different practices and in different parts of the country, without apparent difference in quality and outcomes, and without a clear basis in existing medical evidence. A study published in 2003 looked at regional variations in the

number of services received by Medicare patients who were hospitalized for hip fractures, colorectal cancer, and acute myocardial infraction. The researchers found that patients in higher spending areas received approximately 60 percent more care, but that quality of care in those regions was no better on most measures and was worse for several preventive care measures.[1] Further, there are many examples of steps that physicians have taken to improve quality while helping to keep overall costs down.

Because it is critical for CMS payment systems to support better outcomes for our beneficiaries at a lower cost, CMS is working closely and collaboratively with medical professionals and Congress to consider changes to increase the effectiveness of how Medicare compensates physicians for providing services to Medicare beneficiaries. I am engaging physicians on issues of quality and performance with the goal of supporting the most effective clinical and financial approaches to achieve better health outcomes for people with Medicare. We are committed to developing reporting and payment systems that enable us to support and reward quality, to improve care without increasing overall Medicare costs. When clear, valid and widely accepted quality measures are in place, pay-for-performance is a tool that could enable our reimbursement to better support efforts to improve quality and avoid unnecessary costs.

Currently, hospitals and physicians are paid under separate systems. Under these systems, physicians do not receive credit for avoiding unnecessary hospitalizations by providing better care to their patients. However, in our physician group practice demonstration project, physicians could receive performance based payments derived from savings from preventing chronic disease complications, avoiding hospitalizations, and improving quality of care.

The evidence is increasing that when we provide an incentive for reporting and achieving better quality, health care providers respond by using payments to take a range of steps from the simple to the high-tech to make it happen. This should not really be surprising—our health professionals are dedicated, and they want to do everything in their power to get the best care to their patients. So when we support better quality, we enable them to do what they do best.

We've seen this approach work first-hand with hospital payments where we have tied the annual hospital payment update to quality measure reporting. It has had a positive impact on the availability of quality information, with about 70 percent of hospitals reporting quality data.

Reporting clinically valid quality measures is an important step toward making it easier to achieve major improvements in quality—if you cannot measure it, it is hard to take steps to improve it. We have been working hard in close collaboration with health professionals and other stakeholders to promote the development of better measures.

Voluntary Reporting of Quality Measures Can Be Implemented Soon

Thanks to the leadership and hard work of many physician organizations, we have made considerable progress creating consensus around a set of primary care quality measures. In addition, we have made substantial progress to develop quality measures for the majority of physician specialties. We now have 66 quality measures for 29 specialties. Those 29 specialties represent about 80 percent of Medicare physician spending. We are also developing the infrastructure so that the reporting of these measures on existing physician claims could begin as soon as 2006. While we are still analyzing the issues, we are working out the details so that reporting can be accomplished under existing statutory authorities.

CMS Works with Partners to Develop, Endorse, and Implement Quality Measures

The ability to evaluate and measure quality is an important component in delivering high quality care. For several years, CMS has been collaborating with a variety of stakeholders to develop and implement uniform, standardized sets of performance measures for various health care settings. In recent months, thanks to the leadership of many physician organizations, these efforts have accelerated even further.

Our work on the quality measures has been guided by the following widely-accepted principles. Quality measures should be evidence-based. They should be valid and reliable. They should be relevant to a significant part of medical practice. And to

[1] Fisher, Elliott S., MD, MPH; David E. Wennberg, MD, MPH; Therese A. Stukel, Ph.D.; Daniel J. Gottlieb, MS; F.L. Lucas, Ph.D.; and Etoile L. Pinder, MS, "The Implications of Regional Variations in Medicare Spending. Part 1: The Content, Quality, and Accessibility of Care," in The Annals of Internal Medicine, February 18, 2003, Vol. 138, Issue 4.

assure these features, quality measures should be developed in conjunction with open and transparent processes that promote consensus from a broad range of health care stakeholders. It also is important that quality measures do not discourage physicians from treating high-risk or difficult cases, for example, through a risk adjustment mechanism. In addition, quality measures should be implemented in a realistic manner that is most relevant for quality improvement in all types of practices and patient populations, while being least burdensome for physicians and other stakeholders.

More than two years ago, CMS initiated a process with the National Committee for Quality Assurance (NCQA), the American Medical Association's (AMA) Physician Consortium for Performance Improvement, and other stakeholders to develop measures that would be appropriate for the ambulatory setting. As part of this endeavor, CMS took the lead in supporting the National Quality Forum (NQF) endorsement of ambulatory care measures developed by the NCQA and the Physician Consortium. The NCQA is a private, not-for-profit organization dedicated to improving health care quality by providing information about health care quality to help inform consumer and employer choice. The NQF is a private, not-for-profit membership organization created to develop and implement a national strategy for healthcare quality measurement and reporting. The result of this activity has been the recent endorsement by the NQF of 36 ambulatory quality measures.

Examples of three ambulatory quality measures are the results of the hemoglobin A1C and LDL and blood pressure tests for diabetic patients. The clinical evidence suggests that patients who have a hemoglobin A1C test below 9 percent, an LDL less than or equal to 100 mg/dl, and blood pressures less than or equal to 140/90 mmHg have better outcomes. These measures are evidence-based, reliable and valid, widely accepted and supported, and were developed in an open and transparent manner. Evidence indicates that reaching these goals can lead to fewer hospitalizations by avoiding complications from diabetes such as amputation, renal failure, and heart disease.

Two quality measures endorsed by NQF for heart failure patients include placing the patient on blood pressure medications and beta blocker therapy. Here too, these therapies have been shown to lead to better health outcomes and reduce preventable complications. Together, diabetes and heart failure account for a large share of potentially preventable complications.

In addition to primary care quality measures, other specialties are developing measures. For example, measures of effectiveness and safety of some surgical care at the hospital level have been developed through collaborative programs like the Surgical Care Improvement Program (SCIP), which includes the American College of Surgeons. Preventing or decreasing surgical complications can result in a decrease in avoidable hospital expenditures and use of resources. For example, use of anti-biotic prophylaxis has been shown to have a significant effect in reducing post-operative complications at the hospital level. This measure is well developed and there is considerable evidence that its use could not only result in better health but also avoid unnecessary costs. These post-operative complication measures, which are in use in our Hospital Quality Initiative, are being adapted for use as physician quality measures. Application of this type of post-operative complication measure at the physician level has the potential to help avoid unnecessary costs as well as improve quality.

We also are collaborating with other specialty societies, such as the Society of Thoracic Surgeons (STS), to implement quality measures that reflect important aspects of the care of specialists and sub-specialists. The STS has already developed a set of 21 measures at the hospital level that are risk adjusted and track many common complications as outcome measures. STS is also conducting a national pilot program to measure cost and quality simultaneously, while communicating quality and efficiency methods across regional hubs with the objective of reducing unnecessary complications and their associated cost. The STS measures have been adapted to a set of five quality measures for physicians, such as for a patient who receives by-pass surgery with use of internal mammary artery.

Many other specialties have also taken steps to develop evidence-based quality measures. On July 14, 2005, I sent a letter to many specialty societies, summarizing some of the work to date and requesting an update on their efforts to develop quality and performance measures.

I want to thank the AMA and specialty societies for their very positive response to this effort. Six months ago few specialties had quality measures. Today the majority of specialties have quality measures. Many specialties have created quality task forces and are participating in the quality measurement process. As a result, a total of 66 quality measures now exist covering 29 specialties. These specialties represent about 80 percent of Medicare physician spending. NQF has endorsed 36

of the measures. Activity is underway to prepare the other measures for NQF endorsement. The latest version of all 66 quality measures is attached to this statement.

CMS has had productive exchanges with most medical specialty organizations. I would encourage organizations that have not entered into discussions with us to initiate a dialogue as soon as possible so we can work together to develop clinically valid measures. In certain areas, compliance with evidence-based practice guidelines has the potential to be a quality measure.

The process we have used with the medical profession to develop quality measures beyond ambulatory care should greatly expedite and facilitate the development, acceptance and implementation of quality measures for additional specialties and services. By working in collaboration with the societies, there has been considerable progress in the measure development process. This preparation will facilitate the NQF endorsement process. However, measures that have not yet gone through the NQF endorsement process are still of great value. Physician reporting of these measures will help foster their acceptance in the medical community and help prepare physicians for their eventual adoption. Moreover, since there is likely to be reporting of the quality measures for a period of time before payment based on performance, NQF consensus is not required to begin reporting of such measures. The rapid progress to develop quality measures for the majority of specialties is a clear indication that quality measures are gaining acceptance as an important element in achieving better performance in our health care system.

Our experience with hospital quality measures is that after a measure is endorsed additional work with stakeholders is necessary to assure successful implementation. The Hospital Quality Alliance played an important role in implementation of the hospital quality measures by facilitating hospital adoption and understanding of technical concerns. The Ambulatory Care Quality Alliance (AQA) can serve a similar role to help with physician adoption of the ambulatory quality measures. The AQA is a consortium led by the American Academy of Family Physicians, the American College of Physicians, America's Health Insurance Plans and the Agency for Healthcare Research and Quality, CMS and other stakeholders, including the AMA and other physician groups, as well as representatives of private sector purchasers and consumers.

CMS is Developing a System to Simply Reporting of Quality Measures

The development, endorsement, and consensus process is not sufficient to implement measures successfully. Detailed specifications are needed about such items as the associated diagnosis codes and the rules for reporting (e.g., the ordering vs. performing physician). There is also a key issue about how a payor like Medicare can obtain information on the quality measures. For this reason, while the rapid development of quality measures is ongoing, CMS also has been working on the technical methods for supporting effective, simple, and the least burdensome reporting and payment based on these measures.

In the years ahead, it is expected that electronic record systems can be developed that would provide information that is needed to measure and report on quality while fully protecting patient confidentiality. However, while electronic health records would greatly facilitate the accurate and efficient use of information on quality measures and quality improvement, progress on supporting quality improvement should not be delayed until electronic health records are widely used. Indeed, taking steps now to promote quality reporting and improvement also could promote the adoption of and investment by physicians in electronic records, which would facilitate more efficient quality reporting and quality improvement activities. In the short term, there is considerable evidence that information on a broad range of quality measures can be obtained adequately via information transmitted on existing claims. In particular, with adequate guidance for appropriate coding practices by physician offices, the so-called G-codes, HCPCS codes established by Medicare and reportable on existing claims forms, can be the vehicle to report the information on claims. While HCPCS codes generally represent services furnished, the G-codes would report information on the quality measures, and could potentially be a basis for payment based on the report of such information.

We are in the process of converting all the quality measures into a series of G-codes that could then be reported by a physician on a claim in a way that is simple and does not burden physicians. This reporting mechanism has several advantages. It allows collection of information on the quality measures via an existing system familiar to the physician community. It makes reporting of the information simple for physicians. Furthermore, it allows collection of the quality measures to begin very soon—possibly as early as 2006.

Many changes in Medicare involve changes in the systems used by our contractors to pay claims. We are currently assessing whether changes in our contractor systems might be necessary to implement the reporting of information on the quality measures on claims. We are also assessing implementation issues under a scenario where reporting and subsequent performance could result in a payment differential for physicians.

Many believe that a trial period of a year or two might be appropriate where physicians would report on the quality measures, including quality measures that have broad endorsement and support but that have not yet fully completed a formal consensus process. The bill you introduced, Madam Chairman, H.R. 3617, would begin with reporting and move to performance. Some believe that Medicare could establish a payment differential where physicians who report on the measures get a different payment from physicians who do not report. Many believe that after a trial period for reporting Medicare would then move to a system where the payment differential would be based on performance for the measures.

In many ways, where we are today with reporting quality measures for physicians is analogous to where we were before the MMA enacted section 501, the 0.4 percentage point payment differential for reporting of 10 quality measures. Prior to MMA, mechanisms had been established so that hospitals could voluntarily report information on the quality measures. When MMA was enacted, hospitals quickly responded and most of those institutions that had not previously reported the measures did so. Today there are a total of 20 hospital quality measures. Hospitals can voluntarily report information on the additional 10 measures and such reporting does not have a payment consequence. About 70 percent of hospitals are already reporting on 17 of the measures. Information on all measures reported by hospitals is available on the CMS Hospital Compare website.

The bottom line is that quality measures or indicators have been developed or are well along in the development process for most physicians' specialties. We are currently developing G-codes to report information on these measures on existing claims. We are sorting through systems issues for our contractors. While we still have much work to do, at this point, we believe that we can make rapid progress in very short order so that broad initial reporting of measures that are very relevant to the quality and cost of care for our beneficiaries could begin as soon as 2006.

CMS Works to Ensure Resources are Utilized Appropriately

In many cases, quality measures may help us get more value for our health care dollars. We need to build on this by examining appropriate resource use. The well documented wide variation in resource use among areas for treating the same medical condition raises questions about whether Medicare is getting good value in all areas.

In my June 24 letter to you and Chairman Thomas, I indicated that we supported and were preparing to implement MedPAC's March recommendation to Congress that: "The Secretary should use Medicare claims data to measure fee-for-service physicians' resource use and share results with physicians confidentially to educate them about how they compare with aggregated peer performance."

Measures of physician resource use have been used and are being developed by a number of public and private entities. The most widely used measure of physician resource use is total expenditures per case. Total expenditures include all resources involved in furnishing the case, including physicians' services, laboratory services and other diagnostic tests, hospital services, other facilities, drugs, durable medical equipment, etc.

The measures of resource use are generally applied to episodes of care. The beginning of an episode may be defined by a new diagnosis or treatment, such as hospitalization. Such episodes usually end after claims related to the episode are not present for a defined period of time. Such episodes could include heart attacks or broken hips. For surgeons, coronary bypass surgery and hip replacements would be considered episodes. Episodes also may occur for a full year in the case of chronic diseases, such as diabetes, heart failure, and chronic pulmonary disease.

We are working to implement the MedPAC recommendation using information derived from claims data. We are developing resource use measures that target particular tests and procedures that may be over—or under-used, as overuse is inefficient and under-use raises quality concerns. We also are developing pilot projects that will use software programs created by a number of private sector entities. These programs group services into episodes using claims data. The episodes are then assigned to physicians so average resource use can be computed. We plan to pilot test resource use for a few selected conditions in two states. We are assessing measurement issues such as case-mix/severity adjustment and identification of appropriate comparison groups. Our goal would be to share results with physicians

confidentially to educate them about how they compare to peers and ultimately to incorporate measures related to services, resources, and expenditures into the payment system as envisioned in your bill, H.R. 3617.

Conclusion

Madam Chairman, thank you again for this opportunity to testify on improving how Medicare pays for services. We look forward to working with Congress and the medical community to develop a system that ensures appropriate payments while also promoting the highest quality of care, without increasing overall Medicare costs. As a growing number of stakeholders now agree, we must increase our emphasis on payment based on improving quality and avoiding unnecessary costs to solve the problems with the current physician payment system. Thanks to the leadership of many private-sector organizations working together, and especially thanks to the leadership of physicians, we have made rapid progress in developing quality measures and indicators as well as in building an infrastructure to allow the reporting of such measures. I would be happy to answer any of your questions.

Conversion of Clinial Measures to G-Codes

Physicians Pay-for-Performance

As of: September 26, 2005

Internal Medicine, Family Practice, General Practice

- Diabetic patient with most recent HbA1c level (within the last 6 months) documented as less than or equal to 9%
- Diabetic patient with most recent HbA1c level (within the last 6 months) documented as greater than 9%
- Clinician documented that diabetic patient was not eligible candidate for HbA1c measure
- Clinician has not provided care for the diabetic patient for the required time for HbA1c measure (within the last 6 months)
- Diabetic patient with most recent LDL (within the last 12 months) documented as less than or equal to 100 mg/dl
- Diabetic patient with most recent LDL (within the last 12 months) documented as greater than 100 mg/dl
- Clinician documented that diabetic patient was not eligible candidate for LDL measure
- Clinician has not provided care for the diabetic patient for the required time for LDL measure (within the last 12 months)
- Diabetic patient with most recent blood pressure (within the last 6 months) documented as less than or equal to 140/90 mmHg
- Diabetic patient with most recent blood pressure (within the last 6 months) documented as greater than 140/90 mmHg
- Clinician documented that the diabetic patient was not eligible candidate for blood pressure measure
- Clinician has not provided care for the diabetic patient for the required time for blood measure (within the last 6 months)
- HF patient with LVSD documented to be on either ACE–I or ARB therapy
- HF patient with LVSD not documented to be on either ACE–I or ARB therapy
- Clinician documented that HF patient was not eligible candidate for either ACE–I or ARB therapy measure
- HF patient with LVSD documented to be on B-blocker therapy
- HF patient with LVSD not documented to be on B-blocker therapy
- Clinician documented that HF patient was not eligible candidate for B-blocker therapy measure
- AMI–CAD patient documented to be on B-blocker therapy
- AMI–CAD patient not documented to be on B-blocker therapy
- Clinician documented that AMI–CAD patient was not eligible candidate for B-blocker therapy measure
- AMI–CAD patient documented to be on antiplatelet therapy
- AMI–CAD patient not documented to be on antiplatelet therapy
- Clinician documented that AMI–CAD patient was not eligible candidate for antiplatelet therapy measure
- Patient documented to have received influenza vaccination during the flu season

- Patient not documented to have received influenza vaccination during the flu season
- Clinician documented that patient was not eligible candidate for influenza vaccination measure

Internal Medicine—Cardiology

- HF patient with LVSD documented to be on either ACE–I or ARB therapy
- HF patient with LVSD not documented to be on either ACE–I or ARB therapy
- Clinician documented that HF patient was not eligible candidate for either ACE–I or ARB therapy measure
- HF patient with LVSD documented to be on B-blocker therapy
- HF patient with LVSD not documented to be on B-blocker therapy
- Clinician documented that HF patient was not eligible candidate for B-blocker therapy measure
- AMI–CAD patient documented to be on B-blocker therapy
- AMI–CAD patient not documented to be on B-blocker therapy
- Clinician documented that AMI–CAD patient was not eligible candidate for B-blocker therapy measure
- AMI–CAD patient documented to be on antiplatelet therapy
- AMI–CAD patient not documented to be on antiplatelet therapy
- Clinician documented that AMI–CAD patient was not eligible candidate for antiplatelet therapy measure
- CAD—with LDL documented to be less than or equal to 100mg/dl
- CAD—with LDL documented to be greater than 100mg/dl
- Clinician documented that CAD patient was not eligible candidate for LDL measure
- Counseling on the importance of blood sugar control and monitoring of HgA1c documented to have been provided to patient with diabetes mellitus
- Counseling on the importance of blood sugar control and monitoring of HgA1c not documented to have been provided to patient with diabetes mellitus
- Counseling on the use of antioxidants documented to have been provided to patient with intermediate age-related macular degeneration (AMD), or advanced AMD in one eye, based on data from the Age-Related Eye Disease Study
- Counseling on the use of antioxidants not documented to have been provided to patient with intermediate age-related macular degeneration (AMD), or advanced AMD in one eye, based on data from the Age-Related Eye Disease Study
- Clinician documented that patient with intermediate age-related macular degeneration (AMD), or advanced AMD in one eye (based on data from the Age-Related Eye Disease Study) was not eligible candidate for antioxidant measure
- Central corneal thickness measurement documented for a patient who is primary open angle glaucoma suspect
- Central corneal thickness measurement not documented for a patient who is primary open angle glaucoma suspect
- Clinician documented that patient who is primary open angle glaucoma suspect was not eligible candidate for central corneal thickness measure
- Cataract surgery candidate documented to have been questioned about his/her visual function, including a review of the patient's self-assessment of visual status and visual needs
- Cataract surgery candidate not documented to have been questioned about his/her visual function, including a review of the patient's self-assessment of visual status and visual needs
- A 5% solution of povidone-iodine documented to have been provided as an infection prophylaxis in the pre-operative period for intraocular surgery
- A 5% solution of povidone-iodine not documented to have been provided as an infection prophylaxis in the pre-operative period for intraocular surgery
- Clinician documented that patient at the pre-operative period for intraocular surgery was not an eligible candidate for 5% solution of povidone-iodine infection prophylaxis measure

Surgery—Ophthalmology

- Chronic open angle glaucoma patient documented to have received optic nerve assessment
- Chronic open angle glaucoma patient not documented to have received optic nerve assessment

Surgery—Orthopedic

- Patient documented to have received antibiotic prophylaxis one hour prior to incision time (two hours for vancomycin)
- Patient not documented to have received antibiotic prophylaxis one hour prior to incision time (two hours for vancomycin)
- Clinician documented that patient was not an eligible candidate for the antibiotic prophylaxis one hour prior to incision time (two hours for vancomycin) measure
- Patient with documented receipt of thromboemoblism prophylaxis
- Patient without documented receipt of thromboemoblism prophylaxis
- Clinician documented that patient was not an eligible candidate for thromboemoblism prophylaxis measure

Surgery—General

- ESRD Patient requiring hemodialysis vascular access documented to have received autogenous AV fistula
- ESRD Patient requiring hemodialysis documented to have received vascular access other than autogenous AV fistula
- Clinician documented that ESRD patient requiring hemodialysis was not a candidate for autogenous AV fistula (or other autogenous AV fistula) evaluation measure
- Patient documented to have received antibiotic prophylaxis one hour prior to incision time (two hours for vancomycin)
- Patient not documented to have received antibiotic prophylaxis one hour prior to incision time (two hours for vancomycin)
- Clinician documented that patient was not an eligible candidate for the antibiotic prophylaxis one hour prior to incision time (two hours for vancomycin) measure
- Patient with documented receipt of thromboemoblism prophylaxis
- Patient without documented receipt of thromboemoblism prophylaxis
- Clinician documented that patient was not an eligible candidate for thromboembolism prophylaxis measure

Internal Medicine—Hematology

- Patient with multiple myeloma not in remission documented to be treated with a bisphophonate
- Patient with multiple myeloma not in remission not documented to be treated with a bisphophonate
- Clinician documented that patient with multiple myeloma not in remission was not an eligible candidate for bisphophonate treatment measure
- MDS patient presenting with anemia (Hb < 11 g/dl) documented to have received bone marrow examination, including iron stain, prior to receiving erythropoietin therapy
- MDS patient presenting with anemia (Hb < 11 g/dl) not documented to have received bone marrow examination, including iron stain, prior to receiving erythropoietin therapy
- Clinician documented that MDS patient presenting with anemia (Hb < 11 g/dl) was not an eligible candidate for bone marrow examination, including iron stain, measure prior to receiving erythropoietin therapy
- CLL patient documented to have received confirmation of CLL diagnosis by flow cytometry as part of initial diagnostic evaluation
- CLL patient not documented to have received confirmation of CLL diagnosis by flow cytometry as part of initial diagnostic evaluation
- Clinician documented that CLL patient was not eligible candidate for flow cytometry as part of initial CLL diagnostic evaluation measure
- MDS and acute leukemia patient documented to have received cytogenic testing on bone marrow or peripheral blood (as appropriate) as part of initial diagnostic evaluation
- MDS and acute leukemia patient not documented to have received cytogenic testing on bone marrow or peripheral blood (as appropriate) as part of initial diagnostic evaluation
- Clinician documented that MDS and acute leukemia patient was not an eligible candidate for cytogenic testing on bone marrow or peripheral blood (as appropriate) as part of initial diagnostic evaluation measure

Emergency Medicine

- AMI: Patient documented to have received aspirin at arrival
- AMI: Patient not documented to have received aspirin at arrival
- Clinician documented that AMI patient was not an eligible candidate aspirin at arrival measure
- AMI: Patient documented to have received B-blocker at arrival
- AMI: Patient not documented to have received B-blocker at arrival
- Clinician documented that AMI patient was not an eligible candidate for B-blocker at arrival measure
- PNE: Patient documented to have received antibiotic within 4 hours of presentation
- PNE: Patient not documented to have received antibiotic within 4 hours of presentation
- Clinician documented that PNE patient was not an eligible candidate for antibiotic within 4 hours of presentation measure

Internal Medicine—Gastroenterology

- Clinician documented that patient received conscious sedation consistent with guidelines, including procedural monitoring (ASGE Guidelines)
- Patient received conscious sedation in a manner that was not outlined in the guideline specifications, including procedural monitoring (ASGE Guidelines)
- Clinician documented that patient was not an eligible candidate for conscious sedation measure
- Patient documented to have serum HCV RNA performed prior to initiating HCV antiviral therapy
- Patient not documented to have serum HCV RNA performed prior to initiating HCV antiviral therapy

Internal Medicine—Pulmonology

- COPD patient with documented spirometry evaluation in last 12 months
- COPD patient without documented spirometry evaluation in last 12 months
- COPD patient documented to have received, at least annually, smoking cessation intervention
- COPD patient no documented to have received, at least annually, smoking cessation intervention
- COPD patient documented to have received annual influenza vaccination
- COPD patient not documented to have received annual influenza vaccination

Anesthesiology

- Patient who underwent general anesthesia for greater than 60 minutes documented to have immediate post-operative normothermia
- Patient who underwent general anesthesia for greater than 60 minutes not documented to have immediate post-operative normothermia
- Clinician documented that patient who underwent general anesthesia for greater than 60 minutes was not an eligible candidate for immediate post-operative normothermia measure
- Patient documented to have received antibiotic prophylaxis one hour prior to incision time (two hours for vancomycin)
- Patient not documented to have received antibiotic prophylaxis one hour prior to incision time (two hours for vancomycin)
- Clinician documented that patient was not an eligible candidate for the antibiotic prophylaxis one hour prior to incision time (two hours for vancomycin) measure
- Patient treated with chronic pain management with documented comprehensive history and physical consistent with guidelines (ASA Guidelines)
- Patient treated with chronic pain management without documented comprehensive history and physical consistent with guidelines (ASA Guidelines)

Internal Medicine—Neurology

- Patient with acute ischemic stroke documented to be on anti-thrombotic therapy (aspirin, ticlopidine, clopidogrel, dipyridamole, and warfarin)
- Clinician documented that patient with acute ischemic stroke was not an eligible candidate for anti-thrombotic therapy (aspirin, ticlopidine, clopidogrel, dipyridamole, and warfarin) measure

- Patient with acute ischemic stroke and nonvalvular atrial fibrillation documented to be on warfarin therapy
- Clinician documented that patient with acute ischemic stroke and nonvalvular atrial fibrillation was not an eligible candidate for warfarin therapy measure
- Non-ambulatory patient with acute ischemic stroke documented to have received DVT prophylaxis within the first 24 hours of admission
- Clinician documented that non-ambulatory patient with acute ischemic stroke was not an eligible candidate for DVT prophylaxis measure within the first 24 hours of admission
- Patient with mild to moderate Alzheimer's disease documented to have received centrally acting cholinesterase inhibitors
- Clinician documented that patient with mild to moderate Alzheimer's disease was not an eligible candidate for centrally acting cholinesterase inhibitor measure

Psychiaty

For patients with a newly diagnosed episode of major depressive disorders:

- Patient documented as being treated with antidepressant medication during the entire 12 week Acute Treatment Phase
- Patient not documented as being treated with antidepressant medication during the entire 12 week Acute Treatment Phase
- Clinician documented that patient was not an eligible candidate for antidepressant medication during the entire 12 week Acute Treatment Phase measure
- Patient documented as being treated with antidepressant medication for at least 6 months Continuous Treatment Phase
- Patient not documented as being treated with antidepressant medication for at least 6 months Continuous Treatment Phase
- Clinician documented that patient was not an eligible candidate for antidepressant medication for Continuous Treatment Phase

Internal Medicine—Nephrology

- ESRD patient with documented dialysis dose of URR greater than or equal to 65% (or Kt/V greater than or equal to 1.2)
- ESRD patient with documented dialysis dose of URR less than 65% (or Kt/V less than 1.2)
- Clinician documented that ESRD patient was not an eligible candidate for URR or Kt/V measure
- ESRD patient with documented hematocrit greater than or equal to 35
- ESRD patient with documented hematocrit less than 35
- Clinician documented that ESRD patient was not an eligible candidate for hematocrit measure
- ESRD Patient requiring hemodialysis vascular access documented to have been evaluated for autogenous AV fistula
- ESRD Patient requiring hemodialysis documented to have been evaluated for vascular access other than autogenous AV fistula
- Clinician documented that ESRD patient requiring hemodialysis was not a candidate for autogenous AV fistula (or other autogenous AV fistula) evaluation measure

Internal Medicine and Rehabilitation

- Patient with acute ischemic stroke documented to be on anti-thrombotic therapy (aspirin, ticlopidine, clopidogrel, dipyridamole, and warfarin)
- Clinician documented that patient with acute ischemic stroke was not an eligible candidate for anti-thrombotic therapy (aspirin, ticlopidine, clopidogrel, dipyridamole, and warfarin) measure
- Patient with acute ischemic stroke and nonvalvular atrial fibrillation documented to be on warfarin therapy
- Clinician documented that patient with acute ischemic stroke and nonvalvular atrial fibrillation was not an eligible candidate for warfarin therapy measure
- Non-ambulatory patient with acute ischemic stroke documented to have received DVT prophylaxis within the first 24 hours of admission
- Clinician documented that non-ambulatory patient with acute ischemic stroke was not an eligible candidate for DVT prophylaxis within the first 24 hours of admission measure

Internal Medicine—Rheumatology

- Patient with established diagnosis of rheumatoid arthritis documented to be treated with a DMARD
- Clinician documented that patient with established diagnosis of rheumatoid arthritis was not an eligible candidate for DMARD treatment measure or patient refuses
- Osteoporosis patient documented to have been prescribed calcium and vitamin D supplements
- Clinician documented that osteoporosis patient was not an eligible candidate for calcium and vitamin D supplement measure
- Newly diagnosed osteoporosis patients documented to have been treated with antiresorptive therapy and/or PTH within 3 months of diagnosis
- Clinician documented that newly diagnosed osteoporosis patient was not an eligible candidate for antiresorptive therapy and/or PTH treatment measure within 3 months of diagnosis
- Within 6 months of suffering a nontraumatic fracture, female patient 65 years of age or older documented to have undergone bone mineral density testing or to have been prescribed a drug to treat or prevent osteoporosis
- Clinician documented that female patient 65 years of age or older who suffered a nontraumatic fracture within the last 6 months was not an eligible candidate for measure to test bone mineral density or drug to treat or prevent osteoporosis
- Patients diagnosed with symptomatic osteoarthritis with documented annual assessment of function and pain
- Clinician documented that symptomatic osteoarthritis patient was not an eligible candidate for annual assessment of function and pain measure

Surgery—Neurological

- Patient documented to have received antibiotic prophylaxis one hour prior to incision time (two hours for vancomycin)
- Patient not documented to have received antibiotic prophylaxis one hour prior to incision time (two hours for vancomycin)
- Clinician documented that patient was not an eligible candidate for the antibiotic prophylaxis one hour prior to incision time (two hours for vancomycin) measure
- Patient with documented receipt of thromboemoblism prophylaxis
- Patient without documented receipt of thromboemoblism prophylaxis
- Clinician documented that patient was not an eligible candidate for thromboembolism prophylaxis measure

Surgery—Vascular

- ESRD Patient requiring hemodialysis vascular access documented to have received autogenous AV fistula
- ESRD Patient requiring hemodialysis documented to have received vascular access other than autogenous AV fistula
- Clinician documented that ESRD patient requiring hemodialysis was not a candidate for autogenous AV fistula (or other autogenous AV fistula) evaluation measure
- Patient documented to have received antibiotic prophylaxis one hour prior to incision time (two hours for vancomycin)
- Patient not documented to have received antibiotic prophylaxis one hour prior to incision time (two hours for vancomycin)
- Clinician documented that patient was not an eligible candidate for the antibiotic prophylaxis one hour prior to incision time (two hours for vancomycin) measure
- Patient documented to have required surgical re-exploration
- Patient did not require surgical re-exploration
- Patient undergoing carotid endarterectomy, aortic aneurysm repair, or lower extremity bypass surgery documented to have received pre-operative beta-blockade
- Patient undergoing carotid endarterectomy, aortic aneurysm repair, or lower extremity bypass surgery not documented to have received pre-operative beta-blockade
- Clinician determined that patient undergoing carotid endarterectomy, aortic aneurysm repair or lower extremity bypass was not an eligible candidate to receive pre-operative beta-blockade

- Patient undergoing carotid endarterectomy or lower extremity bypass surgery documented to have received aspirin or clopidogrel within 24 hours
- Patient undergoing carotid endarterectomy or lower extremity bypass surgery not documented to have received aspirin or clopidogrel within 24 hours
- Clinician determined that patient undergoing carotid endarterectomy or lower extremity bypass surgery not a candidate for aspirin or clopidogrel within 24 hours
- Patient undergoing carotid endarterectomy documented to have received heparin during surgery
- Patient undergoing carotid endarterectomy documented not to have received heparin during surgery
- Clinician determined that patient undergoing carotid endarterectomy was not eligible candidate for heparin during surgery
- Patient undergoing carotid stent documented to have received clopidogrel within 24 hours
- Patient undergoing carotid stent documented not to have received clopidogrel within 24 hours
- Clinician determined that patient undergoing carotid stent was not eligible for clopidogrel within 24 hours

Surgey—Thoracic, Cardiac

- Patient documented to have received CABG with use of IMA
- Patient documented to have received CABG without use of IMA
- Clinician documented that patient was not an eligible candidate for CABG with use of IMA measure
- Patient with isolated CABG documented to have received pre-operative beta-blockade
- Patient with isolated CABG not documented to have received pre-operative beta-blockade
- Clinician documented that patient with isolated CABG was not an eligible candidate for pre-operative beta-blockade measure
- Patient with isolated CABG documented to have prolonged intubation
- Patient with isolated CABG not documented to have prolonged intubation
- Patient documented to have received antibiotic prophylaxis one hour prior to incision time (two hours for vancomycin)
- Patient not documented to have received antibiotic prophylaxis one hour prior to incision time (two hours for vancomycin)
- Clinician documented that patient was not an eligible candidate for antibiotic prophylaxis one hour prior to incision time (two hours for vancomycin) measure
- Patient with isolated CABG documented to have required surgical re-exploration
- Patient with isolated CABG did not require surgical re-exploration

Obsterics/Gynecology

- Patient documented to have received antibiotic prophylaxis one hour prior to hysterectomy
- Patient not documented to have received antibiotic prophylaxis one hour prior to hysterectomy
- Clinician documented that patient was not an eligible candidate for antibiotic prophylaxis one hour prior to hysterectomy measure
- Patient documented to have received management of initial abnormal cervical cytology consistent with guideline (ACOG Guidelines)
- Patient documented to have received management of initial abnormal cervical cytology in a manner that was not outlined in the guideline (ACOG Guidelines)
- Clinician documented that patient was not an eligible candidate for management of initial abnormal cervical cytology measure
- Patient with documented receipt of thromboemoblism prophylaxis
- Patient without documented receipt of thromboemoblism prophylaxis
- Clinician documented that patient was not an eligible candidate for thromboembolism prophylaxis measure

Surgey—Plastic & Reconstructive

- Patient documented to have received antibiotic prophylaxis one hour prior to incision time (two hours for vancomycin)

- Patient not documented to have received antibiotic prophylaxis one hour prior to incision time (two hours for vancomycin)
- Clinician documented that patient was not an eligible candidate for antibiotic prophylaxis one hour prior to incision time (two hours for vancomycin) measure
- Patient with documented receipt of thromboemoblism prophylaxis
- Patient without documented receipt of thromboemoblism prophylaxis
- Clinician documented that patient was not an eligible candidate for thromboembolism prophylaxis measure

Internal Medicine Endocrinology/Diabetes/ Metalbolism

- Diabetic patient with most recent HbA1c level (within the last 6 months) documented as less than or equal to 9%
- Diabetic patient with most recent HbA1c level (within the last 6 months) documented as greater than 9%
- Clinician documented that diabetic patient was not eligible candidate for HbA1c measure
- Clinician has not provided care for the diabetic patient for the required time for HbA1c measure (within the last 6 months)
- Diabetic patient with most recent LDL (within the last 12 months) documented as less than or equal to 100 mg/dl
- Diabetic patient with most recent LDL (within the last 12 months) documented as greater than 100 mg/dl
- Clinician documented that diabetic patient was not eligible candidate for LDL measure
- Clinician has not provided care for the diabetic patient for the required time for LDL measure (within the last 12 months)
- Diabetic patient with most recent blood pressure (within the last 6 months) documented as less than or equal to 140/90 mmHg
- Diabetic patient with most recent blood pressure (within the last 6 months) documented as greater than 140/90 mmHg
- Clinical has not provided care for the diabetic patient for the required time for HbA1c measure (within the last 6 months)

Critical Care

Prevention of catheter-related infection

- Patient with documented catheter insertion including the use of sterile barrier precautions in a manner consistent with guidelines for prevention of IV catheter-related infections (CDC Guidelines)
- Catheter insertion performed in a manner that was not outlined in the guideline specifications for prevention of IV catheter-related infections (CDC Guidelines)

Management of catheter-related infection

- Management of patient for catheter-related infection (i.e., staphylococcus A and candida A), including removal of catheter, blood cultures and empiric antibiotics was performed in a manner consistent with guidelines for management of IV catheter-related infections and is documented in chart (IDSA/ACCCM/SHEA/SCCM Guidelines)
- Management of patient for catheter-related infection (i.e., staphylococcus A and candida A), including removal of catheter, blood cultures and empiric antibiotics was performed in a manner that was not outlined in the guideline specifications for management of IV catheter-related infections and is documented in chart (IDSA/ACCCM/SHEA/SCCM Guidelines)

Internal Medicine—Geratic Medicine

For patients 75 years of age or older:

- Patient documented to have received influenza vaccination during flu season
- Patient not documented to have received influenza vaccination during flu season
- Clinician documented that patient was not an eligible candidate for influenza vaccination measure
- Patient documented to have received pneumococcal vaccination
- Patient not documented to have received pneumococcal vaccination
- Clinician documented that patient was not an eligible candidate for pneumococcal vaccination measure
- Patient (female) documented to have been screened for osteoporosis

- Patient (female) not documented to have been screened for osteoporosis
- Clinician documented that patient was not an eligible candidate for osteoporosis screening measure
- Patient documented for the assessment for falls within last 12 months
- Patient not documented for the assessment for falls within last 12 months
- Clinician documented that patient was not an eligible candidate for the falls assessment measure within the last 12 months
- Patient documented to have received hearing screening
- Patient not documented to have received hearing screening
- Clinician documented that patient was not an eligible candidate for hearing screening measure
- Patient documented for the assessment of urinary incontinence
- Patient not documented for the assessment of urinary incontinence
- Clinician documented that patient was not an eligible candidate for urinary incontinence assessment measure

Surgey—Colorectal

- Patient documented to have received antibiotic prophylaxis one hour prior to incision time (two hours for vancomycin)
- Patient not documented to have received antibiotic prophylaxis one hour prior to incision time (two hours for vancomycin)
- Clinician documented that patient was not an eligible candidate for antibiotic prophylaxis one hour prior to incision time (two hours for vancomycin) measure
- Patient with documented receipt of thromboemoblism prophylaxis
- Patient without documented receipt of thromboemoblism prophylaxis
- Clinician documented that patient was not an eligible candidate for thromboembolism prophylaxis measure

Nuclear Medicine

- Patient documented to have received myocardial perfusion imaging examination in a manner consistent with the guidelines, including determination of proper patient preparation (SNM Guidelines)
- Patient documented to have received myocardial perfusion imaging in a manner that was not outlined in the guideline specifications, including determination of proper patient preparation (SNM Guidelines)
- Clinician documented that patient was not an eligible candidate for myocardial perfusion imaging measure
- Patient documented to have received SPECT MPI for an indication rated as appropriate/may be appropriate as outlined in the ACC/ASNC SPECT MPI appropriateness criteria
- Patient documented to have received SPECT MPI appropriateness rating in a manner that was not outlined in the ACC/ASNC SPECT MPI appropriateness criteria or for an indication not specified

Preventive Medicine

- Patient documented to have received influenza vaccination during the flu season
- Patient not documented to have received influenza vaccination during the flu season
- Clinician documented that patient was not an eligible candidate for influenza vaccination measure
- Patient (female) documented to have received a mammogram during the measurement year or prior year to the measurement year
- Patient (female) not documented to have received a mammogram during the measurement year or prior year to the measurement year
- Clinician documented that female patient was not an eligible candidate for mammography measure
- Clinician did not provide care to patient for the required time of mammography measure (i.e., measurement year or prior year)
- Patient documented to have received pneumococcal vaccination
- Patient not documented to have received pneumococcal vaccination
- Clinician documented that patient was not an eligible candidate for pneumococcal vaccination measure

Chairman JOHNSON. Thank you very much, Dr. McClellan. I want to ask you a question that one of the amendments that we proposed to the bill goes to, and it is also mentioned in Dr. Berenson's testimony, if I can find the quote. Well—oh, yes, here he says, but I am suggesting that relative values to determine physician payments should be adjusted to try to accomplish policy goals such as reorienting the care of those with end-stage chronic conditions to palliation and caring rather than curative interventions. Pay for performance might be able to contribute to achieving this reorientation. Now, that is a reorientation that does interest me a lot. The amendment in the bill simply allows you to develop a pool of money from part A and part B. It doesn't compel you to do it. But after all the MEI and MEI minuses is a rather narrow straight jacket in—payment system in which to think about quality. When you look at what the premier system is demonstrating about hospitals' ability to take on a far more aggressive quality program and meet a much broader spectrum of standards, you certainly want to allow that to develop in the physician payment area.

If it developed in the physician payment area, at least I believe that it would give you the tools, this larger pool of money to address situations in which a physician's office practice as a whole becomes a care management group, and eventually to recognize palliative care and the kind of end-of-life care that involves a team management approach and we know would be so fruitful both for the quality of life of our seniors in either of those situations and also so much more respectful of our resources. So, I just wondered whether you think pay for performance as we are thinking about it now, identifying criteria for payment, and then structuring differential payments can enable us to move to a system that is rather more comprehensive in terms of both the number of—the breadth of the team involved and the breadth of their quality performance defined.

Dr. MCCLELLAN. I think the comprehensive approach has a lot to recommend it, and that is reflected in many of our current payment demonstrations and other activities. The fact of the matter is that a lot of the opportunities for improvements in physician care to lead to better outcomes and lower costs have interactions not just in physician offices, but in hospital care and in nursing facility care, in readmissions, in treatments that are classified under part A, but that is a distinction that goes back to the trust fund accounting. It doesn't have reality in actual medical practice. All these costs matter, and some of the best opportunities to avoid unnecessary costs and complications go to part A. In some of the demonstrations that we have under way now, like our physician group practice demonstration, physicians in groups can get additional payments when they take steps to improve quality of care for their patients; for example, meeting appropriate standards of care for patients with diabetes or heart failure and reducing overall cost. We are seeing that some of the best opportunity for reduced costs are in those demonstrations, are in part A, by avoiding emergency room visits, by avoiding readmissions to the hospital and other steps. That is also where the bulk of costs are located. If physicians can have an impact on 1 percent of overall Medicare spending, well, that can translate to a positive update if they are able to

share in those gains. So, it is better outcomes for patients, lower overall costs for the Medicare program, and that is exactly——

Chairman JOHNSON. So, bottom line, avoiding that 45 percent trigger is really about all of Medicare's costs, the biggest costs being hospital and emergency room. If physicians participate in caring for patients in a way that reduces our use of hospital emergency rooms, we have a better shot at avoiding that trigger. But physicians ought to have some compensation or some recognition for developing a far more holistic and preventive approach to patient care. I wanted to just ask you a second question, and then I am going to move on to Pete. The bill also sets up a way—I mean, it says we are going to pay this way for docs, but anybody else covered by the payment system is also going to be paid by this way, but then CMS will have the responsibility they have never had before. Their responsibility in the past is to watch this global target, and when it got breached, doctors would be cut, nobody else would necessarily be cut, and you just struggle with what you do. Under this law, you would have the absolute obligation to watch each group; for instance, you would have the obligation under the law to look at what is happening in imaging, to MedPAC, and need to develop some ways of identifying how much of the growth in imaging is appropriate and how much is inappropriate, and what we can do to control it. Now, I know you have done some things to control it. I think there is more things that you could do. But the thing is it would shine the focus of attention and responsibility on those areas under that target that were growing too rapidly. So, I think actually this bill gives you better control of the spending under the target than the old legislation did. Now, I don't know whether you agree or disagree, and I don't know half as much as about controlling spending as you do, but at least what does that lever do for you?

Dr. MCCLELLAN. I think it does help. Having an emphasis on quality measures is a great way to turn our payment system into a program that supports better care, more efficient care, better outcomes for patients at a lower cost, rather than simply paying more for more services regardless of their quality and their impact on patient outcomes. But——

Chairman JOHNSON. This makes you not only responsible for a different payment system, but also a great deal more accountable for spending increases in the services that doctors prescribe and everything paid for under this section of the law. So, it does increase accountability. Won't that give you a greater incentive to control costs in those individual areas?

Dr. MCCLELLAN. It will simply help provide some incentives, but I think even more importantly, if some of the payments to providers are tied to these areas, they can get the financial support they need to invest in systems that can get those costs down. Right now if providers don't, if hospital and doctors don't coordinate on sending over an X-ray, well, we will just pay for an extra X-ray. You get more money when you have less coordinated care. It would be far better if we paid for better quality at lower costs and then used those financial resources to support doctors and investing in things like electronic medical records which could transmit the

records. We don't pay for that now, and this would be a big change in those incentives.

Chairman JOHNSON. Thank you. Mr. Stark.

Mr. STARK. Thanks, Doctor, for being with us today. I want to just ask you to go back—you brought it up, I wouldn't have, but I am not so sure that I wouldn't ask you to go back and review what you are doing relative to the Katrina/Rita survivors. My sense is that with them being spread all over in different States from which they may or may not formerly have resided, that you have got to do something special in Medicaid, like pay the Medicaid bills for a while or—it ain't going to work. With all these people dislocated, somehow they won't get attention if they—you know, they will be turned away, or get to the bottom or the end of the line if somebody isn't sure that they will get paid for treating them. I am worried about that, and I hope you would consider that.

Dr. MCCLELLAN. Absolutely.

Mr. STARK. There are two questions. First of all, we are going to hear a lot today about the impoverished physicians in the United States, and I just want to—my sense has been on these rate cuts that we are really talking about piecework. It is a fee per procedure. But somehow, very seldom—certainly never mentioned by the AMA, but by others—nobody talks about the income these docs are getting from your Department on the theory that maybe they don't play as much golf, so they do some more procedures. Or maybe they are getting more productive, and so they do it more quickly, and they can do more procedures in the same amount of time. I have got some statements from you over the last 3 years, and it would show us that—well, I do—I must say I feel sorry for the GPs and the general surgeons who are down around the 4 to 6 percent annual increase in payments is what you are paying out, and I presume it mostly goes to them. There may be some overhead in here. So, in spite of the fact that they are talking about reduced fees, their income in the aggregate is going up.

Then you get dermatologists, 13 percent a year on the average; hematologists and oncologists, 24 percent a year increase; even emergency medicine, although that may be the whole bill for the emergency room. I don't know that that is fair, but that is 14 percent. Cardiology is what, 12½ percent—no, a little under 12 percent annual increase, neurology right up there. So, even family practice, who I would have been inclined to think would have taken more of a hit down with the general practice, but at any rate they are not going broke. This is a per-procedure payment. In this discussion, I just want to—and maybe I am missing some something here. I would ask you to correct me if I am, but I don't think I am misleading anybody by suggesting that your records show that you are paying out more each year in spite of the reduced fee for procedure.

But what do you think we should do—let us assume that we are going to give the docs an increase. Let us say it is 2 years. What do you think we should do about the overall control of costs? What is your idea? Would you support going to regional or practice specialty caps? How—what do you see that is out there for us? Because my thought is we would do a couple of years of an increase, but with the idea that the—we are there now. I mean, this will be

the second go-round. But I would hope that we would have something firmly in place that would be a permanent system if we go for a couple-of-year increase.

Dr. MCCLELLAN. Well, first of all, the overall spending growth in part B is very concerning. It is not just physician services, it is essentially all components of part B that have been growing at double-digit——

Mr. STARK. Stop right there. You have about 600,000 docs. Can you give us some—by specialty, some idea of what the income, Medicare income, to these specialty docs has been growing at, which is just to the physician component?

Dr. MCCLELLAN. For the physician component, in the past couple of years it has been growing about 12 percent in total spending. Now it is spending—and out of that you have to remove expenses and so forth, but spending on the practices has been going up at a rapid rate.

Mr. STARK. So, what do we do? Let us say we give them a little more, which I think politically we will be pushed to do. Then what do we do to rebuild this reimbursement system?

Dr. MCCLELLAN. As I said, I don't think the solution is simply putting more money into the current payment system. I think we need to move much more toward focusing on how you get better results at a lower cost. Steps like paying for performance I think can help a lot, but we do need to make sure that any of these steps are done with an eye toward how we keep overall costs on a sustainable path, and with the recent increases in utilization——

Mr. STARK. You are going to propose what?

Dr. MCCLELLAN. I think some of the pay-for-performance steps can make a big difference. We are doing demonstration programs now where we are paying physicians more when they improve quality and——

Mr. STARK. Where were the demonstrations—when could you anticipate, a year, 2 years could we see some results out of the demonstration?

Dr. MCCLELLAN. Absolutely within the next year, and you were talking about a year, 2 years of period with reporting or some other changes, definitely during that time period. We are seeing some results now from the physician group practice demonstration. We are seeing more investment in electronic records, in keeping patients out of the hospital; and even out of the doctor's office, how that is showing up in fewer complications and emergency room visits and admissions. Our hospital payment demonstration, we start it a year earlier, it is showing improvements across the board in performance which lead to fewer readmissions, shorter hospital stays, lower costs. So, I think this evidence is coming up right now. There is also already a lot of evidence from the private sector. You will hear about Bridges of Excellence in a minute, other programs for conditions like diabetes and heart failure; when you pay to get better results, you see better support for physicians to take steps that keep people well and avoid complications. It is a pretty fundamental change in the way our system works, which, as you said, has been piecework up to now.

Mr. STARK. Thank you.

Chairman JOHNSON. I would note that all of those demonstrations allow the issue of, quote, savings to be viewed across the care of the person, so we are able to count in hospital savings and credit them to the work of the physicians. One difficulty in this bill is that CBO refuses to allow that kind of thinking, which is just real-world thinking. It is outside of the box of the ludicrous legislation that we are saddled with, but it is real-world thinking. So, the costs really aren't what they appear to be. Mr. Hulshof.

Mr. HULSHOF. Thank you, Madam Chairman. I always enjoy getting to follow my colleague from California. I would simply say, or make the observation, that even given the statistics cited about areas of specialty—and I certainly don't know everyone in the room, but I think the only people here that get to vote themselves a pay increase every year are those of us up here. So, I would make that observation for what purpose it may serve. Dr. McClellan, I appreciate that you are here. The other observation I would make is a tip of the cap to Chairwoman of this Committee, because this bill was put out over the—before the August district work period, and the fact is that she did that purposely so that everybody could push and pull and yell or praise or talk about this in a constructive fashion. And, in fact, we took that opportunity back home in Missouri to have our physician advisory groups and others weigh in to say whether this is good or bad, what are your concerns. Obviously when you talk about self-reporting and things of that nature, you know, the tendency is to brace yourself. So, I applaud the fact that we have had some good discussion about this.

The easy applause line—and, again, Monday I spoke to a physician group—the easy applause line in any physician group is to say, we think we should toss the HCR overboard. I would recommend, Dr. McClellan, if you want to say that publicly, you are guaranteed to get an applause line. We do need to move to a system that more accurately reflects the cost to providing care. When you have a 4.5-percent increase in one calendar year and looking at a 5.4 percent negative reimbursement the next year, that is not the type of stability that one needs in the practice of medicine. Not only that, to follow up on what Mrs. Johnson has said, the inefficient physicians, the ones that—the efficient physicians that have more in-office visits that might keep that patient out of the hospital setting is going to get reimbursed less than the other physician that has fewer office visits who is willing to just push that patient into some other setting. So, I would think that we are on the right track. I don't know that we can look at this just in the vacuum, however. You mentioned health information technology. So, let me sort of bridge the gap, because I see the momentum is really building for this. I know your views on that, and I applaud those views as far as having some momentum behind being more efficient, not only helping the patient safety aspect, but obviously helping huge costs to the system.

As we move to the system of data collection and dissemination of health care information, what is your perspective on how CMS might be able to coordinate provider reporting requirements with potential electronic standards and private sector initiatives that are likely to come down the pike? Maybe another way to ask the question is do you think that CMS needs to look at—consider mod-

ernizing data collection requirements to keep up with these changing needs? What general thoughts do you have about that?

Dr. MCCLELLAN. I think that will certainly help, and we are in the process of doing that. We are moving to some Internet-based systems toward getting claims processing done now. We have got that going now in Wisconsin and a few other States around the country, and the physicians really like it. It saves a lot of calls to Medicare, and it saves a lot of paperwork. We are going to be phasing that in nationally over the next couple of years. With respect to the quality measures and giving better information on quality so we can support it, I do think that it is feasible to start collecting those measures through reporting in our claims systems in the near future, as soon as next year, but that planning to move from that to a fully electronic system that is based on interoperable health care records and other electronically-based systems that can make the reporting more automatic over several years. If we send a very strong signal that this kind of quality-performing and performance-based payment is important, that is going to create more momentum and support for making the investments necessary in getting widespread electronic health records.

Mr. HULSHOF. So, you see this—from your answer I take it we can do this in tandem then. We don't have to initiate or pay one piece of legislation.

Dr. MCCLELLAN. I see this working together as a gradual but urgent process over the next few years to get to electronic health care and to get to better quality.

Mr. HULSHOF. Thank you. Thank you, Madam Chair.

Chairman JOHNSON. Just to clarify, that is why the bill allows the administration the power to set structural or process criteria and ease the system in that direction. Mr. Thompson.

Mr. THOMPSON. Thank you, Madam Chair. Thank you, Doctor, for being here. I have just seen some AMA numbers that I find very, very alarming. They are talking about some 40 percent of doctors who are going to reduce the number of Medicare patients that they see, and they also talk about the reduction in rural areas of outreach, and I find this troubling for a couple of reasons, not the least of which in rural areas we have another set of problems that we are dealing with, and that is the extreme difficulty we are having in recruiting and retaining physicians in these areas. I see this as the proverbial train wreck coming for anybody who not only represents a rural area, but lives in a rural area and depends upon medical care in those areas. I am wondering, if we cut rates again, this is just going to exacerbate this problem, and it is going to be a real catastrophe for benefactors throughout all rural America. I am just curious as to what CMS has to say about this. I wonder if you have run any estimates on what the real impact is going to be of what the AMA's findings are along with the proposed reductions.

Dr. MCCLELLAN. Well, if those findings were realized, that would be a significant impact. I would even say that we do ongoing analysis and ongoing monitoring of the access of our beneficiaries to physicians in communities all over the country, urban and rural. So, far we have not seen any substantial problems of access to needed care. We haven't seen any problems yet, and as I said a few

minutes ago, if we saw significant negative payment updates, significant reductions in payments year after year, I don't think that is sustainable because I think that would at some point create some real problems in access to care.

Mr. THOMPSON. I would like to invite you to come to my district, and I don't know that you have ever been there before, but I will take you to some places where it is a very real problem. Add to that, as I mentioned before, the recruitment and retention issue, and it is a disaster area. I think you guys should really be aware of that.

Dr. MCCLELLAN. I would like very much to take you up on that and definitely to hear more about it. I have been.

Mr. THOMPSON. I am on an 8 o'clock flight in the morning.

Dr. MCCLELLAN. Thank you for the kind invitation. I was in rural North Dakota recently hearing from some of the providers there who actually would benefit tremendously from reforms in the payment systems that paid more for better outcomes and lower costs. Many of these rural providers are used to having a lot of distance between them and their patients, and they will go from satellite office to satellite office. They have set up relationships with hospitals that may not be in the same community, but they work smoothly together. We need to be doing more to support this kind of high-quality care in rural areas, and I think payment reforms could help do that.

Mr. HULSHOF. Would you yield just a second?

Mr. THOMPSON. Are you next?

Mr. HULSHOF. No. On your time. Now might be a good time to ask for the Dr. Hulshof-Thompson telehealth bill.

Mr. THOMPSON. It is a great author, great bill.

Dr. MCCLELLAN. We will definitely talk with you about it.

Mr. THOMPSON. I like to see anything you have on rural statistics, so——

Dr. MCCLELLAN. Absolutely, and how these kinds of payment reforms can really help rural areas where some of the most innovative idea like telemedicine are being developed to help get the patients the care they need even when doctors are few and far between.

Mr. THOMPSON. Thank you. The second question I have, as you know, I represent an area in this area, locality 99. Sonoma County, I think, was one of the 10 counties that was being reimbursed at a lesser rate, been working on this for a while. Your predecessor came out to Sonoma County and met. You have offered a solution for this which does take care of 2 of the 10 counties—only 2 of the 10 counties—but unfortunately it takes away from the other counties in the area. So, I am in that difficult position where I want to help Sonoma County docs, but at the same time five of my other counties are going to experience, albeit small, but given the problems we are talking about, it is going to be a significant hit. It seems to me that—I will give you the fact this is a good first step, but we really need to look at a bigger solution to this that takes in all of the areas. I don't think we can continue to do the proverbial robbing from Peter to pay Paul; all from Napa and Mendocino to pay Sonoma. All of these areas are experiencing very difficult problems, and how we can reconstruct the reimbursement model is

going to make a difference in who and what kind of health care people get.

Dr. MCCLELLAN. That is absolutely right, and that is why we put this idea out for comment. The comment period on this physician payment, we will close this tomorrow. We are hoping to get better ideas. I have a lot of sympathy for this particular problem having practiced in Palo Alto right over the Santa Cruz Mountains from Santa Cruz, which is another county that is in 99 and affected by the payment issue. But, unfortunately, I can really sympathize with the problem that you are talking about, the zero sum here. We don't have the administrative authority to increase payments across the board. We can only do redistributions with our administrative authority. But we will keep looking as best we can working with you on finding a good solution.

Mr. THOMPSON. CMA had a proposal, as you know, that was a little more fair.

Dr. MCCLELLAN. That would cost money. The problem with that proposal is that we can't do it administratively. We are very much looking for any good ideas in this challenging problem though.

Mr. THOMPSON. Thank you.

Chairman JOHNSON. Thank you. I appreciate the problems that my colleague from California has brought to you attention. I am going to recognize Mr. Emanuel from Illinois, but I do think CMS is significantly underestimating this access problem. The data on the whole of the studies is old, even the AMA data. When you ask doctors are they taking Medicare patients, they mean they are taking new Medicare patients are people they took care of for 20 years and just turned 65. But as you watch older doctors age with their older patient base, there is a limit to how long they can stay in practice if too many of their patients are in the Medicare category and they are in one of these payment areas where they are underpaid. So, Mr. Emanuel.

Mr. EMANUEL. I would like to thank the Chairlady, having come in late, so I apologize to you for not—for missing part of your testimony and some of the earlier questions. I have just got in three areas, if I can. One is I want to add my voice at least on the issues of the IT, information technology. The Chairlady knows of my interest in the issue. Senator Kennedy recently—he and I worked with—passed a bill in the Senate. This is the only place that has low-lying fruit in the sense of any other subject—let us just be honest, we are talking about who is going to pay and shifting cost to who is going to pick up the bill. This is one place where we can actually pick up dollars, do what is right to do, and also find a tremendous amount of synergy there where dollars can either be saved or replowed back into—from savings into the medical field, back into either expanding coverage or other type of care.

My concern is—I raised with the Chairwoman in other meetings on the IT space is not doing what is happening in the mobile telephone areas, setting up too much freedom, and therefore we have a system that doesn't work. We have no improvement there. I do think it should be centrally managed, set up boundaries, and I think Senator Kennedy's legislation is very strong, and I hope we can get something done in this environment. This may be one place

we can get consensus and bipartisan agreement on the IT space as it relates to information technology and medical records, and I look forward to working on that.

Second, in Illinois we have a delegation meeting, Democrat, Republican. There was a big discussion today about the confusion that we are all experiencing at our local offices as relates to the prescription drug bill. I know you have been working hard on trying to clarify that confusion. We have an interest in as a delegation—you may be getting a letter soon—about how Illinois can maybe—to wrap around on the Website some information about—so people in the low-income area on the wraparound don't miss in their coverage. We have a very good State as it relates to helping those who are disadvantaged, and how we can maybe get them the information, and what Illinois is providing to people who are not automatically cut off before they are enrolled. So, heads up, that is coming, a Democrat-Republican——

Dr. MCCLELLAN. I look forward to it. On that point briefly we have been working very closely with the State, as you know, so the State can modify its existing program, its existing Pharmacy Plus waiver to instead have a program that wraps around, as you said, the Medicare benefit. The result is going to be $140 million in savings to the State next year as well as additional coverage for more people to get comprehensive access to prescription drugs. We absolutely share the goal of making sure everyone who is eligible can take advantage of it, because it is such an important program and so much new help with drug costs in Illinois.

Mr. EMANUEL. I think we are all trying to make sure that people who are supposed to be served are getting served. I think there is, A, a step into the unknown. B, there is a sense that Illinois has a good program, and we want to make sure it is dovetailed and is promoted as much as on your Website and on your pages there for people specifically in Illinois. Just a heads up there. Last thing on the subject, if I may, I look at this and I think obviously we have to make some reforms here. My worry here is given the cost, $150 billion over 10 years, and throwing out wholesale this program. If you were—obviously, it needs reform. It was—it solved a problem, but now it is part of a problem. What would be the steps, what—if your ideal—forget the legislative process. What would you keep, and what would you reform? Starting with what you would keep that you think exists in SER that is good, and what would you reform because of the objective? My worry is on the cost control. Where are you going to shift the dollars?

Dr. MCCLELLAN. Well, we need to make sure that physicians are adequately compensated for the care they provide, but right now, we will pay more in cases where care is not well coordinated, where additional services, maybe duplicative services are provided, the kinds of steps that Chairman Johnson has been discussing, the kinds of ideas in pay for performance approaches generally where we shift our payments to instead pay more for better results for patients, better overall care, lower overall costs would make a big difference. We have seen that already in some of our demonstration programs and then some in the private sector. So, that is a very important set of steps that we can take right now because we have quality measures available we can use, we have measures of re-

source use that we can use, and as you said, we can plow in of these savings into supporting IT and other steps to make our healthcare system work better. I think we ought to start doing this right away.

Chairman JOHNSON. Thank you very much. Thank you, Dr. McClellan. I am going to call the panel up so that we can hear everybody on the panel before the bells ring for the next series of votes. Thank you for being with us, and we look forward to working with you as we perfect this legislation, and hopefully move it forward. Dr. Berenson, Dr. Jevon, Karen Ignagni and Dr. Armstrong, if you would come forward. I hope it is not missed on the Committee that this issue, the current volume control mechanism in the physician payment system isn't working. If we somehow can help doctors keep patients out of hospitals and emergency rooms, we will lower overall costs, and that is the most immediate thing we can do to actually begin to flattening out the spending curve. So, it is urgent that we get started. It is also true that we will have to keep working on this. We had to keep working on the other payment system we put in place, and so this is a new beginning, not an end. Dr. Berenson, a pleasure to have you, sir. I read with great interest your testimony. I think that we intend to do more through what we are doing in this bill than you give us credit for, but I am extremely interested in your comments and measurement and on the other STR problems, so I look forward to your testimony.

STATEMENT OF ROBERT BERENSON, M.D., SENIOR FELLOW, URBAN INSTITUTE

Dr. BERENSON. Thank you, Madam Chairman and Mr. Stark and Members of the Committee. As always, I appreciate the opportunity to testify on the Chairman's Medicare Value-based Purchasing of Physician Services Act of 2005. For over 2 decades I have been very interested in physician payment policy as a practicing internist, as a medical director of a preferred provider organization responsible for physician payment, and as a senior official in the centers for Medicare and Medicaid services. I have, in fact, written approvingly of Pay For Performance, a new departure for Medicare and other purchasers and plans to promote improved quality of care. As the payer that often influences market directions, Medicare can play a very important role in leading this activity in collaboration with other purchasers. For different reasons, Pay For Performance for Medicare Advantage plans and for renal dialysis centers seems to me ripe for implementation right now. I have mixed views on the work on hospital measurement in the premier demo, but it seems to be proceeding well.

I generally applaud the goal of measuring physician performance, holding physicians accountable for deviations from desired performance and through publication of their performance, helping Medicare beneficiaries make informed choices about where to get their care. However, there are particularly formidable barriers to assessing performance at the individual physician level, and the current measures that are being adopted are not relevant for many Medicare patients, especially those with multiple chronic conditions and those who are quite old. More work needs to be done in this area. In addition, in the crucial areas of overuse and inefficient provision

of services, and in misuse, that is, errors of commission or faulty judgment, measures are in their infancy, and there is only so much I believe that you can do with administrative data. So, I would conclude—in my introduction, I would make the point that the state of the art of Pay For Performance does not permit it to be the solution to all healthcare problems. It has a role, but I think we are loading too much on Pay For Performance.

The physician payment system used by most private insurers and by Medicare is based on the Fee-for-service Payment Model. The payments reimburse for transactions, not for population-based healthcare, and the powerful inherent incentives and fee-for-service for reimbursements are to drive up volume. Recent data from both Medicare and private payers document that that is exactly what is happening and volume is being increased to unsustainable levels. In this fee-for-transactions environment, the validated Pay For Performance measures that mostly address primary and secondary prevention services and patient experiences with care likely will have little effect on utilization spending, even as they improve patient outcomes. So, I looked with interest at the G-codes that Administrator McClellan provided with his testimony, the kinds of measures that physicians will be asked to submit, and they are, indeed, related to underservice in some very specific important areas, but are tangential to the issue of healthcare costs and what is driving healthcare costs.

The Sustainable Growth Rate Mechanisms needs to be reformed or replaced, and while significant changes are needed, current Pay For Performance measures that focus on underuse of preventive services simply will not serve as a substitute for the STR mechanism. It seems to me that this well-intentioned attempt is an example of the tail-wagging the dog, by that I mean the engine that drives physician behavior is the financial incentive to increase volume. Physicians, especially those who may knowingly take advantage of that system, will surely ignore any marginal payment incentive of one or 2 percent if the behavior to gain the marginal income conflicts fundamentally with the underlying incentives in the payment system. It would be much easier to do an extra test, see an extra patient, or of most concern, simply upcode visits to make up for what otherwise would be lost under such a scenario. While there is no conflict between the underlying payment incentives and a Pay For Performance approach that rewards more care, that won't contain costs or limit inappropriate utilization.

So, I am concerned that the attention on Pay For Performance to some extent is distracting policy makers and the medical profession from addressing what are increasingly apparent flaws in the resource base relative value scale payment system that controls physician payment in Medicare, and in somewhat altered form in many private health plans. Very briefly, physicians—Medicare's physician payments system is facing fundamental problems that Pay For Performance alone will not address in which few policy makers seem to have paid attention to in recent years. There is a disconnect between what we pay physicians and the underlying cost of production of those services. Recently MedPAC did a study on specialty hospitals and the DRG payment system documenting the problem on hospital payments. I would assert that there are

similar distortions in the physician payment system that is driving physicians to procedural services and away from evaluation management services.

Again, there is little to no volume or cost control incentives in the system. When you have a national volume performance control, you are basically treating all physicians the same when we know there are particular areas of problems in certain—like imaging services that are going up 20, 25 percent a year. Major surgical procedures are not increasing out of control, evaluation management office visits are not, but in some areas, we do have problems, and yet we have an STR mechanism that is applied nationally and treats all physicians the same.

Then finally, the point that you made in your remarks earlier; we have no particular coding mechanism for encouraging physicians to actually do care coordination or to hire staff who can do care coordination. Again, I am not—I would love Pay For Performance to give incentives for physicians to do that, but as long as we have a fee-for-service system that is using 7,000 codes that document what the professional activities are that physicians get to be reimbursed for, until we get to the robust Pay For Performance system that I think we all hope for, we should define some of those services as reimbursable, and try to redirect physician services. So, let me conclude by simply saying, I like Pay For Performance, I applaud your leadership and Dr. McClellan's activities to try to get us on that road, but I think we have loaded onto it too much baggage; it is not going to solve all of our problems, and in particular, it is not going to solve the volume and cost problem in part B. Thank you very much.

[The prepared statement of Dr. Berenson follows:]

Statement of Robert Berenson, M.D., Senior Fellow, Urban Institute

I would like to thank Chairman Johnson and members of the Subcommittee on Health of the Ways and Means Committee for the opportunity to testify on the Chairman's Medicare Value-Based Purchasing of Physicians' Services Act of 2005. For over two decades, I have followed the evolution of Medicare's policies for compensating physicians under part B—as a practicing internist, a medical director of a preferred provider organization responsible for the physician fee schedule, a senior official in the Centers of Medicare and Medicaid Services overseeing payment policy for all providers, and a policy analyst and commentator.

I have had the opportunity of looking at the issues that H.R. 3617 raises from virtually all sides and conclude that although pay-for-performance efforts are important and show promise, they should not be viewed as a substitute for the flawed sustainable growth rate mechanism for controlling physician spending. There are important and largely overlooked issues in the underlying payment system that have been all but ignored in this debate and which are long overdue for attention.

First Steps on Pay-For-Performance

I have written approvingly of pay-for-performance (P4P) as a new departure for Medicare and other purchasers and plans to promote improved quality of care. Given the disappointing state of quality, where it can be measured, providing incentives for physicians to do better seems an appropriate response. As the payer that often influences market directions, Medicare can play a uniquely important role in leading this activity in collaboration with other purchasers. Indeed, two years ago a group of highly respected health care leaders from across the ideological spectrum agreed in an open letter in *Health Affairs* that Medicare should lead on P4P. A particularly desirable attribute of P4P is holding providers accountable against validated measures of performance, rather than just paying claims for services rendered.

The presence of validated and useful measures, as well as an evolving culture that has accepted the desirability of meeting objective performance measures, means

that certain providers are ready to participate in such a system. For health plans, the nearly two decades old work on HEDIS and CAHPS measures and the tedious but essential implementation work under the leadership of the National Committee for Quality Assurance suggests that P4P can be a useful approach to rewarding performance and improvement by Medicare Advantage plans. In addition, ESRD providers are ripe for P4P because of the presence of widely accepted process measures that are good predictors of the outcomes of dialysis. In fact, MedPAC recommended that P4P commence in Medicare with these two provider categories.

I have mixed views about the readiness of hospitals for P4P, but the Premier demonstration seems to be off to a good start, and, importantly, the expectations of what P4P can accomplish in the hospital sector are appropriately limited; that is, the marginal incentive for hospitals to meet explicit performance on the core CMS measures are not integral to hospitals' basic reimbursement. Importantly, the basic approach to hospital payment relies on prospective payment through case rates—diagnosis related groups (DRGs). Although, as we all learned through the MedPAC study of specialty hospitals, DRG payments can be skewed and create distorted incentives for hospitals to emphasize certain services at the expense of others, nevertheless, the hospital prospective payment system creates the basic incentives for hospitals to improve efficiency, at least in caring for the patients that enter through their doors. P4P is not looked to for the purpose of improving hospital efficiency.

Physician Pay-For-Performance

Which brings me to the subject of today's hearing—pay-for-performance for physicians in Medicare. Here, I would make a point about terminology. I have chosen to use the term pay-for-performance rather than value-based purchasing, the term that the Chairman has adopted to title the proposed bill. I believe value-based purchasing is a much broader concept than pay-for-performance, which is but one of many strategies that a value-based purchaser might adopt.

I generally applaud the goal of measuring physician performance, holding physicians accountable for deviations from desired performance, and through publication of performance, helping Medicare beneficiaries make informed choices about which physicians they should seek care from. However, there are formidable barriers to assessing performance at the individual physician level. Further, in the crucial areas of overuse and inefficient provision of services and in misuse, that is, errors of commission and faulty judgment, measures are in their infancy.

Physician pay-for-performance faces unique barriers in Medicare because of certain characteristics of the Medicare beneficiary population. In an important article that appeared last month in the *Journal of the American Medical Association*, a group at Johns Hopkins cogently argued that most clinical practice guidelines (CPGs) and performance measures focus on single conditions, failing to recognize that many Medicare beneficiaries have multiple chronic conditions, not just a single one for which most guidelines and measures are directed. The authors concluded, "Basing standards for quality of care and pay for performance on existing CPGs could lead to inappropriate judgment of the care provided to older individuals with complex comorbidities and could create perverse incentives that emphasize the wrong aspects of care for this population and diminish the quality of their care."[1] It will take years to develop validated measures relevant to the large number of beneficiaries with complex comorbidities.

A related issue is that most CPG and P4P measures are relevant to younger populations. For an 85 year-old, measures that focus on primary and secondary prevention are not particularly relevant, whereas measures appropriate to geriatric syndromes, e.g. reducing falls, addressing incontinence and chronic pain, deserve priority. I recognize that H.R. 3617 calls for measures that address issues related to frail elderly and those with multiple chronic conditions, but the work to develop age-relevant performance measures is just beginning.

One P4P initiative that seems to be on the right track is the California-based activity under the auspices of the Integrated Healthcare Association. However, it is important to identify the unique aspects of IHA that suggest to me it will not be simple to replicate the approach in Medicare. The IHA initiative assigns accountability to relatively large multi-specialty medical groups contracting with health plans under capitation arrangements that, similar to DRGs for hospitals, transfers financial risk to the provider group. The fundamental approach to promoting cost conscious physician behavior resides in the basic professional capitation payment to the groups. In this context, P4P provides an important complement by looking for

[1] Cynthia M. Boyd, et al., Clinical Practice Guidelines and Quality of Care for Older Patients With Multiple Comorbid Diseases. *JAMA* 294(6): 716–723.

and measuring possibly substantial under-use of services, which is a potential by-product of incentives that could lead to withholding needed care. Importantly, there are reasonable process measures of under-use for certain important diseases that also supports the goals of the IHA initiative.

In contrast, the Medicare physician payment system and, outside of California and a few other places, the physician payment system used by most private insurers based on a fee-for-service (FFS) model. The payments reimburse for transactions, not for population-based health care, and the powerful, inherent incentives in FFS reimbursements are to drive up volume. Recent data from both Medicare and private payers document that that is exactly what is happening—to unsustainable levels. In this fee-for-transactions environment, the validated P4P measures that mostly address primary and secondary prevention services and patient experiences likely will have little effect on utilization and spending even as they improve patient outcomes. Further, where patients have free choice of physician at the point of service, as in Medicare, PPOs and, now, many HMOs, patients obtain care in an *a la carte* fashion, providing no easy way to assign the responsibility for performance. It is far easier to attribute performance against specified measures to multi-specialty groups that assume responsibility for individuals who designate them as their source of care than to independent physicians who take patients one by one and face no incentives to conserve resources. Physicians are supposed to meet the standards of care of their specialty, not assure that patients actually have good outcomes at a reasonable cost. Thus, pay for performance offers some promise as a tool to move physician orientation to actually meeting patients' needs. We will see.

In short, physician P4P faces formidable barriers in Medicare, as it does for most private plans. For all the P4P talk, the current round of Center for Studying Health System Change (HSC) Community Tracking Study site visits found that physician P4P was underway robustly only in 2 of the 12 metropolitan areas that it tracks—in Orange County, in the heart of the delegated capitation model of care and in Boston, where there are large physician groups, often attached to the major teaching hospitals.[2] Although Medicare surely could lead on P4P, I doubt that P4P is ready for the decisive role envisioned for it under the Chairman's proposed legislation, a role that sees it as a substitute for the flawed sustainable growth rate (SGR) formula for holding down Part B expenditures.

P4P is Not a Subsitute for the Troubled SGR Mechanism

The SGR needs to be reformed or replaced. While significant changes are needed, current P4P measures that focus on under-use of preventive services simply will not serve as a substitute for the SGR mechanism for constraining physician spending in Medicare. The well-intentioned attempt, unfortunately, strikes me as a classic example of the "tail wagging the dog." By that I mean that the engine that drives physician behavior is the financial incentive to increase volume. Physicians, especially those who may be knowingly taking advantage of the system, will surely ignore any marginal payment incentive of 1 or 2 percent if the behavior to gain the marginal income conflicts fundamentally with the underlying incentives in the payment system. It would be much easier to do an extra test, see an extra patient, or—of most concern—upcode visits to make up for what otherwise might be lost under such a scenario. While there is no conflict between the underlying payment incentives and a P4P approach that rewards more care, that won't contain costs or limit inappropriate utilization. To the contrary, it might increase spending, albeit for desired activities.

But on issues of overuse, I suggest that the conflict does exist. For example, in Medicare spending for advanced imaging services increased last year by 25 percent. Because much of the costs associated with imaging services are fixed and able to be spread over the number of imaging services provided, those providing these services have every incentive to suggest the need for additional, discretionary imaging services. And referring physicians, for various reasons, face no constraint on ordering imaging services that, importantly, do no harm, except to taxpayers and the relatively few beneficiaries without supplemental insurance who actually have to pay a co-payment. Thus, even if we could reliably measure overuse, I am skeptical that physicians will markedly change their behavior to respond to a modest 1–2 percent change in payment.

In short, pay-for-performance is a worthy initiative and I applaud the goal of trying to produce relevant and validated measures for each specialty. However, I ex-

[2] Cara S. Lesser, Paul B. Ginsburg and Laurie E. Felland, Initial Findings from HSC's 2005 Site Visits: Stage Set for Growing Health Care Cost and Access Problems. Center for Studying Health System Change, Issue Brief 97, August 2005.

pect that this objective done correctly would take many years. The current state of measurement and structural impediments to P4P effectiveness does not constitute an acceptable substitute for the SGR, which I think we all agree needs to be replaced.

The RBRVS System Needs A Comprehensive Review

I am concerned that the attention on P4P is distracting both policy makers and the medical profession from addressing what are increasingly apparent flaws in the resource-based relative value scale (RBRVS)-based payment system that controls physician payment in Medicare and, in somewhat altered forms, in private health plans.

As suggested earlier, a value-based purchaser asks whether it is obtaining the right kind and mix of services, of acceptable quality, for the right cost. For example, a value-based purchaser would not simply defer to the medical profession to determine the mix and relative value of services provided by the profession, the explicit concept that underlies the RBRVS-based payment system. Further, a value-based purchaser would feel no obligation to provide payment bonuses to all specialties if the areas of that need improvement could be affected by a subset of physicians. The goal of value-based purchasing, with P4P as but one strategy, should be to provide greater value for beneficiaries and taxpayers, not to promote equitable access to bonus payments for physicians, which seems to be the American Medical Association's position. Thus, P4P should be seen a means to the end of getting greater value for money spent and not as an end in itself, that is, to measure and reward for the sake of measuring and rewarding.

Given the problems in the Medicare physician payment approach that preceded RBRVS, basing payment on dollar estimates of work and practice overhead, rather than historic charges, was a clear improvement. And in the first decade of implementation beginning in 1992, the volume control mechanisms that limited spending functioned reasonably well. Unfortunately, those days are over.

Briefly, Medicare's physician payment system is facing fundamental problems that pay-for-performance alone will not address and to which few policymakers seems to have paid attention in recent years.

1. Disconnect between costs and payments. For many services, payments bear poor relation to underlying cost of production. The MedPAC finding that skewed DRG payments were distorting market behavior in relation to specialty hospital development is surely also true in relation to physician payments. Recently, Paul Ginsburg and Joy Grossman of the Center for Studying Health System Change wrote about this phenomenon of distorted payments in relation to hospital and ambulatory care based upon recent findings from the 12 HSC Community Tracking Sites.[3] I am currently reviewing HSC interviews from the fifth round of site visits that demonstrate that physician behavior too often reflects a strong bias toward performing procedures, even leading them to be unavailable to perform the consultative role that specialists traditionally have performed. For example, in some sites, gastroenterologists have stopped caring for complex hospitalized patients, preferring to perform routine endoscopies in ambulatory endoscopy suites in which they are likely to have ownership interests. In short, physicians respond to economic incentives, which has distorted physician behavior, resulting in the provision of an inappropriate mix of services. MedPAC has identified the issue of mispricing of physician services and plans to study it in detail in the near future.[4]

One of the explicit objectives of the RBRVS system based on work performed by William Hsiao and colleagues, was to redistribute from procedural and technical services to what were then called "cognitive" services and now "evaluation and management" services. Although there was initial redistribution in implementing the RBRVS system in 1992, a preliminary Urban Institute study I helped produce for MedPAC demonstrated that desired redistribution progress has stopped for a number of reasons.[5]

Compounding the problem within the physician fee schedule is the apparent overpayment in facility fees, which are paid separately from the physician fee schedule, As a result, many physicians now invest in ambulatory surgery centers, endoscopy suites, and diagnostic imaging and testing centers. In short, to make up for what they consider inadequate professional fees, in particular for their time associated

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[3] Paul B. Ginsburg and Joy M. Grossman **When The Price Isn't Right: How Inadvertent Payment Incentives Drive Medical Care** *Health Affairs* Web Exclusive, August 9, 2005

[4] Chapter 9: Review of CMS's Preliminary Estimate of the Physician Update for 2006 in "Report to the Congress: Issues in a Modernized Medicare Program" MedPAC, June 2005.

[5] MedPAC Report, June 2005.

with patient visits and consultations, physicians increasingly are becoming entrepreneurs, able to self-refer to increase volume and revenues. Thus, in any serious attempt to fix the SGR mechanism, consideration should be given to redirecting savings from reducing overly generous facility fees to the pool of dollars that physicians can receive for their professional services, so that physicians can again resume their roles of acting in their patients' best interests and performing services they have been trained for, rather than feel a need to self-refer to support their investments. Again, MedPAC is doing some work in this area, at least with respect to examining site-of-service differentials.

2. Volume or cost control. Many have described the problems of the SGR as the mechanism for controlling physician expenditures. Preceding the SGR was the Volume Performance Standard (VPS), which had problems as well, but was reasonably successful in the face of the daunting volume incentives that fee-for-service provides. I believe one of the problems in both approaches is that the volume control is applied at a national level. When prices are cut as a result of national volume controls, an individual physician's incentive is to increase services that do no harm to patients, of which there are many. Thus, prudent physicians are penalized and profligate ones are rewarded. This reality does provide a strong rationale for individual level assessments of utilization as performance measurement attempts to do. But again, the physician who is increasing volume to increase revenues that go to the bottom line is unlikely to respond to a P4P incentive of a percentage point or two to restrain volume.

Interestingly, in recommending a national volume control mechanism that was subsequently adopted in statute as the VPS, the Physician Payment Review Committee (PPRC) understood that a control mechanism applied nationally was a crude approach. In 1989, the PPRC expressed hope that organized medicine would step up to the challenge of developing clinical practice guidelines, enhanced peer review and other professionally-grounded approaches to reducing excessive volume. That never happened. PPRC also discussed moving to specialty specific and geographic volume performance standards to target price cuts to where the excessive volume was taking place. That never happened either.

And now, more than fifteen years later, we understand through the work of Jack Wennberg, Elliot Fisher and their colleagues that geographic variations in volume of physician services do not produce important differences in quality. We are spending too much in particular geographic areas, but the volume controls are being applied nationally. Further, not all services are rising at unacceptable rates. The volume of major surgical procedures is not rising out of control; nor are doctor visits. Yet, the SGR spreads the pain of price cuts indiscriminately. In short, the SGR mechanism is broken, but as long as Medicare reimburses for professionally-determined transactions, there needs to be more targeted volume control mechanisms to address inflationary spending. We are asking too much of P4P to do the job of controlling volume increases and the accompanying unsustainable spending increases.

3. Lack of care coordination for beneficiaries with chonic conditions. The current physician payment system does virtually nothing to promote care coordination by physicians and their offices for the increasing numbers of beneficiaries with multiple chronic conditions. These patients typically see numerous unconnected physicians and other health professionals and may take ten or more prescription and OTC drugs without supervision. The Chairman knows of my interest in this area. I have had the privilege of testifying here on how to improve the provision of services to beneficiaries with chronic illnesses, and I applaud the Chairman for her interest in helping enact important pilots and demonstrations in the Medicare Modernization Act that are now proceeding. Nevertheless, I continue to believe that physicians have a crucial role to play in being part of teams that address the care for patients with multiple chronic conditions. To achieve that objective, basic payment policy must provide incentives for physicians to spend some of their professional time and to allow others working under physician supervision to take part in care coordination activities.

Simply, the Current Procedural Terminology (CPT) coding system that Medicare and private payers use does not address care management and care coordination. Frankly, care coordination is not an easy thing to define and pay for. Nevertheless, a value-based purchaser would ask how to promote the set of activities that Ed Wagner and colleagues have delineated to constitute good chronic care management. At the same time a value purchaser would try to offset that new spending by reducing the volume of services that are serving no useful purpose, such as intensive care unit stays for many patients in their last weeks and months of life.

I am not recommending arbitrarily limits on what services patients are eligible for. But I am suggesting that relative values that determine physician payments should be adjusted to try to accomplish policy goals, such as reorienting the care

of those with end-stage chronic conditions to palliation and caring, rather than curative interventions. Pay—for-performance might be able to contribute to achieving this reorientation. But the real action is in the nitty-gritty coding and payment policy that has seemed on automatic pilot for the past decade.

Conclusion

In summary, I think measuring physician performance and moving to greater accountability for that performance is a desirable goal. But I am concerned that inflated expectations about what pay-for-performance can achieve has diverted attention from the increasingly evident problems with many aspects of the basic physician payment system. In particular, P4P currently does not provide a plausible mechanism for controlling the volume of or spending on physician services. The RBRVS-based payment approach has been a very important alternative to what came before and worked well initially. But a number of problems with the RBRVS conceptual foundation and its implementation have now become apparent. MedPAC has identified some of the issues that I have briefly discussed above, with tentative plans to explore them in greater detail.

Measurement of physician performance and attempts to pay differentially for performance should proceed, but P4P currently will not address soaring volume increases of certain physician services in particular geographic areas. P4P should not distract the committee from a long overdue look at the basic payment system. As part of that review, I believe better alternatives to the SGR will be found. And until we have a solution, I think it unwise to simply repeal the SGR.

Chairman JOHNSON. Thank you very much, Dr, Berenson. Dr. Jevon.

STATEMENT OF THOMAS JEVON, M.D., PRACTICING FAMILY PHYSICIAN, WAKEFIELD, MASSACHUSETTS

Dr. JEVON. Madam Chairman, Congressman Stark, Members of the Ways and Means Health Subcommittee, I would like to thank you very much for the opportunity to testify before you today regarding my experience participating in the Bridges to Excellence program and other Pay For Performance programs. My name is Dr. Tom Jevon, I am a solo family physician practicing in a solidly middle class suburb about 15 miles north of Boston. I may be among a rare group of physicians in that I have used an electronic medical record since 1993. As a practicing physician in an area dominated by very large HMOs, as a leader of a 300 doctor physician hospital organization, and as a member of a large network of providers, including Mass General and Brigaman Women's Hospital, I have a lot of experience with financial incentives for physicians. I truly believe that most physicians support the concept of Pay For Performance measures. They support the idea of rewarding their colleagues who work harder and demonstrably do a better job than their peers. For Pay For Performance plans to work, however, they need to meet a number of criteria. Most important, Pay For Performance only works for the primary care physician like myself when real dollars are at stake. It takes a bonus of $2,000 to get a physician interested, probably $5,000 to grab his or her attention. The proposed differential of 1 percent in the current draft of the bill would probably translate into perhaps a thousand dollars, not enough to engage a doctor in the effort.

The Pay For Performance has to capture the imagination, or at least the attention of the doctor; we have to believe the goal or measure will actually make a difference, that is, both improve patient health, and hopefully improve the healthcare delivery system.

The Bridges to Excellence program pays physicians bonuses if they show success in treating diabetics better with improved education programs and objective laboratory-based measures of diabetic control. The Pay For Performance has to be transparent, accurate and fair. Our major source of data for physician performance is the claims physicians submit to be paid for services. Unfortunately, this claims data is often inaccurate, delayed, and in many ways flawed. This can cause all kinds of disturbing results, such as the doctor universally known by his colleagues to be a weak or inferior clinician achieving top scores on a patient satisfaction index and being rated as a top physician in an HMO network. We must improve our data and measurement techniques by being careful about what we choose to measure and ensuring the integrity of our data. Bridges to Excellence has been very careful in this regard, they do not rely on claims to evaluate physician performance. They also choose measures that can be accurately measured and verified.

The physician effort to improve performance, including the physician's cost to collect the data, can't outweigh the financial benefit to be gained. In my own experience, I decided not to apply for the Bridges to Excellence diabetic program because the bonus I would achieve was not worth the word. On the other hand, the bonus for me for an EMR was significant, more than $5,000. It was an easy decision to apply for it. We need to create grant programs or provide pools of cash for special purposes when there isn't enough funding to make significant cash payments to all physicians. In my own PHO, we decided to give grants to a few earlier adopters of electronic medical records. Medicare should encourage programs like Bridges to Excellence that are simply bonuses, programs that offer straightforward transparent rewards that are not wrapped up in health insurance contracts, or simply the return of expected physician fees. Like it or not, bonuses without strings attached improve performance and outcomes. Physicians must be intimately involved in both the design and implementation of measures that report relative physician quality. If the measure is unfair or flawed by bad data, there is likely to be a huge backlash or disengagement or disenchantment from physicians.

My own perspective is an that EMR is essential to any long-term success with Pay For Performance. Access to an EMR allows collaboration between patients, physicians and other healthcare providers and can provide the accurate data we need to truly and fairly measure relative physician performance and quality, and develop fair Pay For Performance models. It allows us to move away from our dependence on claims data for measuring physician performance. To most physicians, Pay For Performance is just the latest iteration in the struggle to control costs, while at the same time improving quality. Physicians appreciate that if they are not willing to engage in this on-going battle, insurers and government will impose possibly Draconian solutions. Yet many physicians are angry because on top of the real business of healing, they are often caught in the middle of doing society's job of deciding how to deploy health resources all day, every day with every patient. For older doctors, this is certainly not what they signed up for, nor was it what they were trained for. As we design new payment programs to incentivize physicians, we should not forget the multiple, dif-

ficult and conflicting challenges that hardworking physicians face each day. Thanks very much for the opportunity to present my views.

[The prepared statement of Dr. Jevon follows:]

Statement of Thomas Jevon, M.D., Practicing Family Physician, Wakefield, Massachusetts

Madame Chairman, Congressman Stark, and Members of the Ways and Means Health Subcommittee, I would like to thank you for the opportunity to testify before you today regarding my experience participating in the Bridges to Excellence Program and other Pay for Performance Programs.

My name is Dr. Tom Jevon, and I am a solo family physician practicing in a solidly middle class suburb 15 miles north of Boston. I am a typical primary care physician with a very busy practice seeing a wide range of patients 5 days a week with both evening and Saturday hours. I may be atypical in that I have used my own EMR (Electronic Medical Record) since 1993 and have been deeply involved in managed care for 15 years, not only as a practicing physician in an area dominated by large HMO's but as director of medical management and vice president for the 300 physician PHO (Physician Hospital Organization) in our area. I am currently heading an effort to create a central, shared EMR for the physicians in our PHO, which we plan to implement in early 2006. I've also been involved in PCHI, (Partners Community Health Care Inc) a large network of community hospitals, physician groups and academic centers including Massachusetts General Hospital and Brigham and Woman's Hospital, since it's inception more than 10 years ago. I have grappled with the issues of different financial incentives for physicians for years, both as a practicing physician and in my various administrative roles. Our present contracts contain multiple pay for performance measures, mostly an opportunity for physicians to win back money withheld from their fees. Public reporting and measurement of physician quality as well as tiered patient co pays based on these results are also coming to our marketplace.

Pay for Performance

I truly believe that most physicians support the concept of Pay for Performance Measures. They support the idea of rewarding their colleagues who work harder and demonstrably do a better job than their peers. For Pay for Performance plans to work however they need to meet a number of criteria, many of which Chairwoman Johnson has elaborated in her legislation.

However, Pay for Performance only works when real dollars are at stake. Physicians are relatively insensitive to measures that provide less than $2000 in their pocket. The 1% differential in the Johnson bill would probably translate into perhaps $1000 into the average primary care physician's pocket, probably not enough to engage him in the effort. To really grab a physician's attention you need to be in the $5000 and up range. Specialists with higher incomes may have a higher threshold and generally require programs that are different from those for primary care physicians.

Pay for Performance has to capture the imagination or at least the attention of the doctor: We have to believe the goal or measure will actually make a difference and either improve patient health or make our system work better. The Bridges to Excellence (BTE) program pays physicians bonuses if they show they really succeed in treating diabetics better, with improved education programs and objective laboratory based measures of diabetic control.

Pay for Performance has to be transparent, accurate and fair: Our major source of data for physician performance is the claims physicians submit to be paid for services. Unfortunately this claims data is often inaccurate, always delayed and often flawed in many different ways. In my PHO we have achieved hundreds of thousands of dollars for our physicians, not by helping them achieve their performance goals but by digging through data that starts out as looking improbable or unusual and then turns out to be simply in error. This has nothing to with Pay for Performance and every thing to do with flawed data. Once the data is "clean" there are further hurdles; we need to apply adjustments for Health Status, patient compliance and other factors unique to our local environment. Even then we can see disturbing results like the doctor universally known by his colleagues to be a weak clinician achieving top scores on a patient satisfaction index and being rated as a top physician in an HMO network.

We must improve our data and measurement techniques, by being careful about what we choose to measure and ensuring the integrity of our data. Our PHO uses

claims data to measure physician performance with diabetics with mixed results. Documenting annual eye visits has been challenging, documenting blood and urine tests, less so. Measures around physician performance with radiology based on claims data has been very problematic. BTE has been very careful in this regard. They do not rely on claims to evaluate physician performance. They also choose measures that make sense and can be accurately measured and verified.

The physician effort and cost of achieving a goal or simply obtaining the appropriate data to measure that goal cannot overwhelm the financial benefit to be gained: Physicians are far too busy and overworked already to take on something that is clearly not worth the effort. I decided not to apply for the BTE Diabetic program because the bonus I would achieve was not worth the work. On the other hand the bonus for me for an EMR was significant, more than $5000. It was an easy decision to apply for it. I paid a $475 fee to register with the National Committee for Quality Assurance, (NCQA) and document my system's capabilities with their web-based tool. They evaluated my submission and certified that I met their criteria for the Physician Office Link program.

When there isn't enough funding to make significant cash payments to all physicians create grant programs or provide pools of cash for special purposes. We have decided to give grants to early adopters of EMR in our PHO.

Medicare should encourage programs like Bridges to Excellence that are true value added programs and offer straightforward, transparent rewards that are not wrapped up in health insurance contracts or simply the return of withheld physician fees. My own experience with BTE was relatively painless. I used a NCQA website and screenshots from my system to document exactly how my EMR was used, what data it routinely contained on blinded patients. There were discreet criteria that had to be met to achieve different levels or reward. For doing this I received both recognition and a cash award. It felt good to be paid a bonus without strings attached for going above and beyond the average physician.

Physicians must be intimately involved with both the design and implementation of measures that report relative physician quality. If the measure is unfair or flawed by bad data there is likely to be a huge backlash or disengagement or disenchantment from physicians.

I support many of the recommendations of the February 10th, 2005 Statement for the Record by Wendy Gaitwood from the American Academy of Family Physicians. Specifically I support those recommendations that require feedback to physicians about the data, disclosure of the sources of the data, and assurances through the use of a 3rd party that the data has been validated and verified.

Conclusion

My own perspective is that an EMR is essential to any long-term success with Pay for Performance. Access to an EMR/EHR allows collaboration between patients, physicians and other health care providers, and can provide the accurate data we need to truly and fairly measure relative physician performance and quality and develop fair P4P models. It allows us to move away from our dependence on claims data for measuring physician performance. EMR has its own challenges, not the least of which are: huge changes in physician style of practice, high costs both in dollars and physician time to implement, ongoing expense to maintain, and a perceived threat to physician autonomy. But I believe its benefits far outweigh its costs, and it is really the only way forward.

To most physicians, Pay for Performance is just the latest iteration in the struggle to control costs while at the same time improving quality. Physicians appreciate that if they are not willing to engage in this ongoing battle, insurers and government will impose possibly draconian and noxious solutions. Yet physicians are angry because, on top of the real business of healing, they are often caught in the middle doing society's job of deciding how to deploy health resources all day, every day with every patient. For older doctors this is certainly not what they signed up for, nor was it what they were trained for. We all yearn for something like the lawyer's role in society: Serve only the needs of your client and leave all concern about the costs to society resulting from your actions to someone else. As we design new payment programs to incentivize physicians we should not forget the multiple, difficult and conflicting challenges that hardworking physicians face every day.

Thank you, again, for the opportunity to present my views.

Chairman JOHNSON. Thank you very much for your excellent testimony. Ms. Ignagni.

STATEMENT OF KAREN IGNAGNI, PRESIDENT AND CHIEF EXECUTIVE OFFICER, AMERICA'S HEALTH INSURANCE PLANS

Ms. IGNAGNI. Thank you, Madam Chair and Mr. Stark, Members of the Committee, it is a pleasure to be here this afternoon. As we were listening to the discussion, it occurs to me to begin with the obvious, and all of you have mentioned it today. We face three core challenges in healthcare, controlling costs, improving quality and expanding access. The interrelationship of these challenges is encapsulated in data provided by the Rand Corporation that indicates only 55 percent of healthcare services nationwide are delivered in accordance with best practices. The payment system hasn't encouraged a do-it-right-the-first-time attitude or commitment to best practices. Indeed, until recently, efforts in the private sector payments for good care, bad care or mediocre care has been the same, and wide variations and practice patterns have been ignored.

Further exacerbating these trends quite seriously are data recently reported in JAMA, indicating that physicians feel that they are forced to practice defensive medicine with almost half reporting that they used imaging technology in clinically unnecessary circumstances. A dollar spent on unnecessary or duplicative procedures is a dollar that could ameliorate the burden of rising costs on employers and consumers, and be devoted toward improving access or maintaining benefits in public programs. These problems clearly didn't arrive overnight and they will not be solved overnight.

As we move to considering how to move in the direction of incenting quality, we think it is very critical to link that conversation to the matter of reliable data. We are happy to offer comments on these broad issues, as well as specifically on H.R. 3617. In our written testimony, we emphasize the following points: One, the importance of uniform performance measurement to reduce the proliferation of multiple uncoordinated and conflicting data requests going to physicians from health plans, from employer coalitions, from consultants and public sector. Two, the need to aggregate data, to facilitate the reporting the data that fairly represents the patient population served by a provider. We can't expect that a particular provider should be judged by his or her population served from a particular health plan, from a particular public program, we need to aggregate data.

Three, we need to report data to consumers to help them make more informed decisions back to providers so that they can improve quality of care. Four, any legislation in our view should require public officials to work with established groups working on the data elements I mentioned above rather than reinventing the wheel. Five, the measures should be updated regularly to reflect new evidence, new understandings and new information.

Our testimony also discusses and provides some examples of private sector experience with innovative payment arrangements. An important lesson we have learned is that quality and efficiency measures go hand in hand. Many of our members are offering physician financial rewards, others offer nonfinancial rewards in the form of public recognition, preferential marketing or streamlined administrative procedures. Still other programs provide lower co-

pays deductibles or premiums to consumers who choose providers found to be of higher quality, based on specific performance measurement.

AHIP and our members are active participants in the Ambulatory Care Quality Alliance, AQA, which is working on the matters I referred to above. The objective of that alliance is to create uniformity in performance-based initiatives. The AQA members include numerous physician groups, the American College of Physicians, the Academy of Family Physicians, the American Medical Association, the Osteopathic Association, the Society For Thoracic Surgeons, the College of Surgeons, the AARP, the National Partnership For Women and Families, the Pacific Business Group on Health, the Agency For Healthcare Research and Quality, and CMS.

Together, these organizations are working to identify what should be measured for proficient performance, both quality and efficiency, and develop a data aggregation model that will comprehensively assess provider performance. We hope these efforts will be useful to the Committee by putting in motion baseline work that needs to be done to make this transition to a quality-based payment system a success. Earlier this year, AQA reached consensus on a common set of 26 ambulatory care performance measurements to provide clinicians, consumers and purchasers with a starter set, but it is only that, and now we are working on additional sets of quality measures. But it is a beginning.

More recently, AQA has been focused on developing pilot projects that combine public and private payer data, leveraging the experience of existing data aggregation efforts and evaluating the most effect processes for measuring physician level performance. We think that this is an important matter to begin this work and to begin the conversation. AQA is currently seeking to secure both public and private funding to implement these pilot projects in 2006, and we are very optimistic about that. AQA has also developed fundamental principles for reporting reliable and useful quality information to consumers and providers, and we would be delighted to share that with the Subcommittee. In closing, Madam Chair, thank you for the opportunity to testify. We applaud the beginning of this conversation, and we would like to be as helpful as possible in working on the issues that all of the members referred to in their opening statements this afternoon. Thank you.

[The prepared statement of Ms. Ignagni follows:]

Statement of Karen Ignagni, President and Chief Executive Officer, America's Health Insurance Plans

I. INTRODUCTION

Good afternoon, Madam Chairwoman and members of the subcommittee. I am Karen Ignagni, President and CEO of America's Health Insurance Plans (AHIP), which is the national trade association representing nearly 1,300 private sector companies providing health insurance coverage to more than 200 million Americans. Our members offer a broad range of health insurance plans to employers, state and federal governments, and individuals, and also have demonstrated a strong commitment to participation in Medicare, Medicaid and other public programs.

We appreciate this opportunity to testify, and to share our thoughts with you about H.R. 3617 and the importance of establishing payment incentives that promote quality, safety, and efficiency goals. Indeed, this experience indicates that paying for quality and efficiency is a promising strategy for improving overall health care outcomes and advancing evidence-based medicine.

Historically, health care practitioners have not been paid based on the quality of care they deliver. Until recently, positive clinical outcomes, high patient satisfaction, and efficiencies have not been rewarded. Instead, provider reimbursement—particularly in the Medicare program—has been based on the volume and technical complexity of services rendered. This approach rewards any over-utilization and misuse of services, and results in higher payments when health care complications arise. In effect, the current financing system creates disincentives to improve quality and efficiency. More tests, more visits, and repeated hospital stays are rewarded, whereas efficiency, effectiveness and getting it right the first time are not.

The flaws of the current system are recognized by physicians. A 2004 survey [1] of 400 primary care and specialty physicians, conducted on behalf of AHIP by Ayres, McHenry & Associates, found that 86 percent of physicians are concerned that the current payment system does not reward practitioners for providing high quality medical care. Other findings of this survey indicate that 71 percent of physicians favor payments based in part on the quality of care they provide, and 62 percent believe that information on the quality of care provided by a physician should be made available to the public.

Additionally, this survey included other findings which may be relevant to the subcommittee's discussions. Specifically, an overwhelming majority of physicians indicate support for pay-for-performance programs if the performance measures were developed with physicians in that particular medical specialty (87 percent), if the performance measures were clearly communicated to physicians before they were used in payment arrangements (84 percent), and if the performance measures were evidence-based and grounded in science (83 percent).

II. THE CASE FOR CHANGE

The U.S. health care system faces a number of significant challenges. Rising health care costs are threatening to make health coverage unaffordable for more Americans, and are holding back efforts to meet the needs of the uninsured.

Rising Costs

The most recent data from the Department of Health and Human Services (HHS) project that national health care spending increased by an estimated 7.5 percent in 2004. Although this is the lowest rate of increase since 2000, health care costs still are growing faster than the overall economy and, as a result, large and small employers are finding it more difficult to provide or maintain coverage for their employees.

AHIP and our members are encouraged about what we can do in the private sector to reduce growth in health care spending. From 1994 through 1999, national health expenditures were in line with overall economic growth, because health insurance plans implemented a variety of tools to constrain costs. This had a direct impact on the ability of employers to purchase affordable coverage for their employees.

Indeed, the Lewin Group estimated that up to 5 million people [2] who otherwise would have been uninsured were able to receive coverage as a result of these costs being restrained.

As the policy debate shifted away from containing costs, legislative proposals at both the federal and state levels focused on rolling back the mechanisms that were keeping health care affordable. This led to a new cycle of accelerating health care costs with a2deleterious effect on purchasers and consumers.

Recognizing this challenge, our members have developed a new generation of cost containment tools that already are having a positive impact and showing promise for the future. For example, the rates of increase in pharmaceutical expenditures have significantly declined as a result of our members' implementation of programs to encourage greater use of generic drugs and other measures that encourage case management of chronic conditions. The Center for Studying Health System Change has reported [3] that growth in prescription drug spending fell to 7.2 percent in 2004, down from almost 20 percent in 1999.

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[1] "National Survey of Physicians Regarding Pay-for-Performance," Ayres, McHenry & Associates, Inc., September/October 2004

[2] The Lewin Group LLC, *Managed Care Savings for Employers and Households: 1990 through 2000*; 1997

[3] Strunk, B., Ginsburg, P., & Cookson, J. (June 2005). *Tracking Health Care Costs: Spending Growth Stabilizes at High Rate in 2004*. Center for Studying Health System Change. Data Bulletin No. 29.

Quality Concerns

Through its landmark reports released in 1999, *To Err is Human*, and in 2001, *Crossing the Quality Chasm*, the Institute of Medicine (IOM) focused the nation on the critical need to improve health care quality and patient safety, coordinate chronic care, and support evidence-based medicine. Variation in medical decision-making has led to disparities in the quality and safety of care delivered to Americans. The 1999 IOM report[4] found that medical errors could result in as many as 98,000 deaths annually, and a 2003 RAND study[5] found that patients received only 55 percent of recommended care for their medical conditions.

A wide range of additional studies indicate that Americans frequently receive inappropriate care in a variety of settings and for many different medical procedures, tests, and treatments. Such inappropriate care includes the overuse, underuse or misuse of medical services. Studies also show that patterns of medical care vary widely from one location to another, even among contiguous areas and within a single metropolitan area—with no association between higher intensity care and better outcomes. For example:

- *The Dartmouth Atlas of Health Care*[6] documents wide variation in the use of diagnostic and surgical procedures for patients with coronary artery disease, prostate cancer, breast cancer, diabetes, and back pain. For example, the rates of coronary artery bypass graft (CABG) surgery were found to vary from a low of 2.1 per 1,000 persons in the Grand Junction, Colorado hospital referral area, to a high of 8.5 per 1,000 persons in the Joliet, Illinois region. The Atlas' most recent findings[7] reveal wide variation in hospital care and outcomes for chronically ill Medicare patients. For example, the length of hospital stays varied—depending on a patient's geographic location—by a ratio of 2.7 to 1 for cancer patients and by a ratio of 3.6 to 1 for congestive heart failure patients.
- The longstanding nature of quality problems in the U.S. health care system is evidenced by a 1999 article[8] in The New England Journal of Medicine, which stated:"A number of studies have demonstrated overuse of health care services; for example, from 8 to 86 percent of operations—depending on the type—have been found to be unnecessary and have caused substantial avoidable death and disability." A more recent study, published in the June 1, 2005 edition of the Journal of the American Medical Association[9], indicated that 93 percent of practicing physicians in the state of Pennsylvania reported practicing defensive medicine—with 43 percent reporting that they used imaging technology in clinically unnecessary circumstances.
- The National Committee for Quality Assurance (NCQA) [10] documents the state of health care quality annually, reporting in 2004 that "enormous quality gaps'" persist as "the majority of Americans still receive less than optimal care" with between 42,000 and 79,000 avoidable deaths occurring each year. While health care quality is improving in some areas, the health care system remains "deeply polarized, delivering excellent care to some people, and generally poor care to many others."

These research findings clearly indicate the need for innovative strategies to improve quality and efficiency throughout the U.S. health care system. Decisive action is needed to address these wide-ranging variations in medical decision-making, as well as the overuse, underuse and misuse of health care services. While we understand that the subject of this hearing is paying for quality, we have thoughts about other strategies that could support these efforts and would be delighted to share them with the subcommittee.

III. WHERE WE GO FROM HERE

We need to move toward a health care system that rewards physicians, hospitals and other health care practitioners for high quality performance. Although the private sector is implementing programs to meet this challenge, it is time for Medicare

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[4] "To Err is Human," Institute of Medicine, 1999

[5] "The Quality of Health Care Delivered to Adults in the United States.," Elizabeth A. McGlynn, RAND, June 25, 2003

[6] Center for the Evaluative Clinical Sciences, Dartmouth Medical School, The Dartmouth Atlas of Health Care, "The Quality of Medical Care in the United States: A Report on the Medicare Program," 1999

[7] Fisher, E., *Health Affairs,* October 7, 2004

[8] Dr. Bodenheimer, T., *The New England Journal of Medicine*, Vol. 340, No. 6, pp. 488–492, 1999

[9] "Defensive Medicine Among High-Risk Specialist Physicians in a Volatile Malpractice Environment," *Journal of the American Medical Association*, June 1, 2005.

[10] NCQA, The State of Health Care Quality: 2004, 2004

and other federal programs to make similar changes and reward health care practitioners for best practices and improved patient outcomes. This would be an important step toward advancing an evidenced-based health care system that yields better health outcomes and greater value for beneficiaries.

We applaud you for introducing legislation—H.R. 3617, the "Medicare Value-Based Purchasing for Physicians Act of 2005"—to provide incentives to physicians to provide high quality health care. We support the objectives of improving quality, efficiency, patient safety and satisfaction, and believe that a strong commitment to these goals will result in benefits to a variety of key stakeholder groups. Consumers benefit from public disclosure and the opportunity to select the best practitioners. Clinicians who perform well will be sought after, and all clinicians will benefit from receiving feedback on how their performance compares to their peers. For public programs, transitioning to a payment-for-quality system will improve care and shrink the wide variation in practice patterns around the country.

AHIP's members are committed to working with stakeholders across the health care community, particularly health care professionals who work on the frontlines every day, to develop a strategy that accounts for the quality of care delivered to patients. In November 2004, AHIP's Board of Directors demonstrated this commitment by approving principles that are in sync with the goals underlying H.R. 3617 and at the same time offer additional thoughts for advancing quality-based payment systems. AHIP's principles include eight key elements:

- Programs that reward quality performance should promote medical practice that is based on scientific evidence and aligned with the six aims of the IOM for advancing quality (safe, beneficial, timely, patient-centered, efficient, and equitable).
- Research is urgently needed to inform clinical practice in priority areas currently lacking a sufficient evidence-based foundation.
- The involvement of physicians, hospitals and other health care professionals in the design and implementation of programs that reward quality performance is essential to their feasibility and sustainability.
- Collaboration with key stakeholders, including consumers, public and private purchasers, providers, and nationally recognized organizations, to develop a common set of performance measures—process, outcome and efficiency measures—and a strategy for implementing those measures will drive improvement in clinically relevant priority areas that yield the greatest impact across the health care system.
- Reporting of reliable, aggregated performance information will promote accountability for all stakeholders and facilitate informed consumer decision-making.
- The establishment of an infrastructure and appropriate processes to aggregate—across public and private payers—performance information obtained through evidence-based measures will facilitate the reporting of meaningful quality information for physicians, hospitals, other health care professionals, and consumers.
- Disclosure of the methodologies used in programs that reward quality performance will engage physicians, hospitals, and other health care professionals so they can continue to improve health care delivery.
- Rewards, based upon reliable performance assessment, should be sufficient to produce a measurable impact on clinical practice and consumer behavior, and result in improved quality and more efficient use of health care resources.

IV. IMPORTANCE OF UNIFORM PERFORMANCE MEASUREMENT, DATA AGGREGATION AND REPORTING

Performance Measurement

A critically important step in moving forward with programs that reward quality performance is the development of a uniform, coordinated strategy for measuring, aggregating and reporting clinical performance. Disseminating information derived from *aggregated* performance data—which provides stakeholders with a more comprehensive view of performance across marketplaces—would yield benefits on several levels. Consumers would be allowed to make more informed decisions about their health care treatments. Physicians, hospitals and other health care professionals would be better able to improve the quality of care they provide. Purchasers would receive greater value for their investment in health care benefits. Health insurance plans could continue to develop innovative products that meet consumer and purchaser needs.

Unfortunately, the nation lacks a uniform and coordinated strategy for measuring and aggregating physician performance data. While many different private and public sector groups have attempted to step up to the challenge by designing models

for assessing performance and reporting data, the proliferation of multiple, uncoordinated and sometimes conflicting initiatives has significant unintended consequences for different stakeholders. For example, duplicative efforts:

- unnecessarily burden physicians, other clinicians, and health insurance plans with different data requests, shifting focus away from quality and efficiency improvement;
- create confusion among consumers due to different information that is being publicly reported; and
- detract from collective efforts to efficiently make decisions and design programs that meet broad quality goals.

Perhaps most important, however, are the adverse effects numerous initiatives have on patient care and the health care system as a whole. Without a uniform approach to select performance measures for public reporting, they will continue to divert limited resources and focus away from establishing clear priorities and reaching goals.

To create uniformity across purchasers, coalitions and consulting firms, AHIP has been working in a collaborative effort with the Ambulatory Care Quality Alliance (AQA), whose membership also includes the American College of Physicians (ACP), the American Academy of Family Physicians (AAFP), the American Medical Association, the American Osteopathic Association, the Society for Thoracic Surgery, the American College of Surgeons, AARP, the National Partnership for Women and Families, the Pacific Business Group on Health, and the Agency for Healthcare Research and Quality (AHRQ), with the support of the Centers for Medicare & Medicaid Services (CMS). Together, these organizations are working to identify what should be measured for physician performance—both quality and efficiency—and develop an effective and efficient data aggregation model that would comprehensively assess provider performance.

The AQA recently reached consensus on a common set of 26 ambulatory care performance measures. These measures are grouped under eight separate categories: (1) prevention; (2) coronary artery disease; (3) heart failure; (4) diabetes; (5) asthma; (6) depression; (7) prenatal care; and (8) overuse or misuse of medical services. Many of the measures under these categories are "bundled" measures—i.e., multiple measures which if used collectively, have the potential to more comprehensively and accurately assess physician performance and provide improved outcomes for patients.

These measures are intended to serve as a "starter set" that will provide clinicians, consumers, and purchasers with a set of quality indicators that can be used for quality improvement, public reporting, and pay-for-performance programs. Over the next several months, AQA will be seeking to expand this starter set to include efficiency, patient experience, non-primary care and other key measures.

Data Aggregation

In addition to working toward a strategy for performance measurement, AQA is developing a uniform data aggregation strategy. The aggregation model developed by this alliance would include the following key attributes:

- transparency with respect to framework, process and rules;
- a process that allows provider performance to be compared against both national and regional benchmarks and makes the data useful for physicians to improve the quality and efficiency of care they provide to their patients;
- collection of both public and private data so that physician performance can be assessed as comprehensively as possible;
- a process that facilitates public reporting to consumers of user-friendly and actionable information about physician quality and efficiency;
- standardized and uniform rules associated with measurement and data collection; and
- potection of privacy and confidentiality of data while ensuring necessary access to appropriate stakeholders.

Launching Pilots

A first step toward achieving this model is to implement pilot projects that combine public and private payer data, leverage the experience of existing aggregation efforts, and evaluate the most effective processes for measuring physician-level performance. AQA—which at its last meeting reached consensus on the need and value for pilots—is currently seeking to secure both public and private funding to implement such pilots in 2006.

Key elements of the proposed pilots would include:

- assessment of clinical quality, efficiency and patient experience;
- collection and aggregation of Medicare claims data and private sector data from multiple sources;
- exploration of both existing and new methods for collecting, submitting and sharing data from physicians' medical practices;
- dissemination of measurement information.

The proposed pilots would address numerous important issues, including the most effective methods for linking measures, and data from multiple sources; the most effective ways to address methodological issues (e.g., sample size for validating physician performance, how to attribute performance to particular physicians, and which risk-adjustment model is most effective); and what type of information should be reported back to physicians and other stakeholders. We believe that these pilot efforts could inform the subcommittee's discussions, and we hope you will be supportive of this broad effort.

Consumer Reporting

AQA is also exploring strategies for reporting reliable and useful quality information to consumers, providers and other stakeholders. The Alliance recently developed fundamental principles for reporting with the objectives of facilitating more informed decision-making about health care treatments and investment, facilitating quality improvement, and informing providers of their performance. Two AQA committees are working on this issue—one specifically addressing the issue raised in H.R. 3617 about how to communicate these data to physicians; and the other focusing on how to communicate this information to consumers. We hope this effort, which involves a broad range of stakeholder groups, also will be helpful to your discussions.

The AQA will continue to move forward in the areas of measurement, aggregation and reporting, and encourage various stakeholders to become involved in this important effort to improve health care quality and patient safety. The work currently being undertaken by the AQA, including the development of a common set of measures and pilot projects which aggregate public and private sector data, will help us reach our goals of identifying quality gaps, controlling skyrocketing cost trends, reducing confusion and burdens in the marketplace, and otherwise addressing the challenges of the current health care system.

V. COMMENTS ON H.R. 3617

We appreciate this opportunity to offer for your consideration comments on key elements of H.R. 3617.

A. Characteristics and Fairness of Performance Measures

Health plans strongly support the criteria set forth in H.R. 3617 for performance measures. Many of these characteristics—such as the requirement that measures should be evidence-based, valid, and not overly burdensome to collect—are consistent with the criteria endorsed by the Ambulatory Care Quality Alliance (AQA). Similarly, the other criteria set out in the bill—such as outcome measures; process measures; structural measures (e.g., use of health information technology); measures of overuse, misuse and underuse; and measures that assess the relative use of resources, services or expenditures—have been recognized by the AQA as critical areas that need to be addressed. We, at the same time, urge the committee to consider supporting other important characteristics endorsed by the AQA, including that measures be aligned with the IOM's six aims for improvement (safe, effective, patient-centered, timely, efficient and equitable), that physician-level measures should as much as possible complement measures in other health care settings and that measures should as much as possible be constructed so as to result in minimal or no unintended harmful consequences (e.g., adversely impact access to care).

Health insurance plans agree that performance measures should be applied and implemented fairly. This requires that measures be appropriately risk-adjusted to take into account differences in individual health status and conditions, and that an adequate sample be used to ensure a statistically valid assessment of physician performance. Fairness also requires the use of outcomes measures, as well as measures that reflect processes of care that physicians can influence (e.g., measures that assess the appropriate treatment for children with upper respiratory infection and the appropriate testing for children with pharyngitis).

B. Selection Process for Measures

A good deal of work is currently being done to create a robust measurement set that can be used on a uniform basis for performance-based payments throughout the health care system. The National Committee for Quality Assurance (NCQA) has

been working with the health plan and purchaser communities to create programs, such as Bridges to Excellence, that align incentives around higher quality, efficient care. The AMA Physician Consortium for Performance Improvement, which includes representation from 70 national medical specialty societies, has been working to develop evidence-based clinical performance measures to improve patient care and foster accountability. The National Quality Forum (NQF) reviews the work of these organizations and other entities in an attempt to reach consensus on a preferred set of performance measures and quality reporting. The Ambulatory Care Quality Alliance, (AQA) which includes the involvement of NCQA, the AMA Consortium and NQF—along with CMS and AHRQ—strives to reach consensus across purchasers, physicians, consumers and health plans on the most appropriate performance measures that have been endorsed by NQF or validated through experience for immediate use. The AQA currently is working to gain consensus on common rules and logic for efficiency measures, as well as targeting those performance measures that address underuse, overuse and misuse. Given the depth and breadth of ongoing work, we believe it is essential for the Secretary to work with these groups in selecting quality and efficiency measures as opposed to reinventing the wheel. The selection of measures not currently being utilized by the private sector will create unnecessary inconsistency, add confusion, and impose an additional burden on physicians. By contrast, the collaborative efforts of the AQA are paving the way for greater standardization and uniformity in value-based purchasing initiatives.

C. Periodic Revision of Measures

It is important that quality and efficiency measures be evaluated periodically for their relevance and ability to improve care. To evaluate improvements in care, trending data is important; for example, a minimum of two years of data are needed to evaluate provider efficiency. Thus, periodic review and revision should occur in a timely period. However, as new evidence becomes available, these measures should be revised as soon as possible to reflect such evidence, while not being disruptive to data collection efforts.

D. Disclosure and Reporting

Public reporting will encourage quality performance. While our members believe that physicians should be involved actively in the selection of measures and reviewing information before it is disclosed, such processes should ensure the timely provision of meaningful information.

VI. THE PRIVATE SECTOR'S EXPERIENCE

Your proposal for a value-based purchasing program in Medicare is similar in many respects to initiatives that many private sector health insurance plans have implemented in recent years. Health insurance plans have long been at the forefront of developing innovative payment arrangements that have promoted population-based health care, improved care for the chronically ill, and encouraged prevention.

Many of our members currently are offering financial awards to physicians in the form of increased per-member-per-month payments or non-financial rewards in the form of public recognition, preferential marketing or streamlined administrative procedures. Additionally, some plans are offering consumers reduced co-payments, deductibles, and/or premiums in exchange for using providers deemed to be of higher quality, based on specific performance measures. The categories of performance measures most commonly reported include clinical quality, utilization experience/efficiency, patient satisfaction, and information technology infrastructure. Specific examples of these initiatives are outlined in Appendix A.

While still in their early stage in some markets, initiatives that reward quality and tier clinicians according to how they achieve quality goals have an early track record in several states, including California, Massachusetts, and Michigan. What we have learned is that quality and efficiency measures go hand in hand.

Based on the experiences of our members, we know that programs for rewarding quality performance have a number of common features:

- **Reason for Implementation:** Across the board, the programs seekto enhance and sustain clinical quality, facilitate excellence across provider networks, and improve and promote patient safety.
- **Role of Clinicians:** Nearly all plans indicate that clinicians are actively involved in key aspects of rewarding quality performance programs, including program development, selection of performance measures, and determination of how rewards are linked to provider performance.
- **Emphasis on Specific Measures:** In rewarding quality performance programs for physicians and medical groups, achieving clinical quality goals plays the most significant role in the formula for determining financial rewards. In pro-

grams for hospitals, utilization experience/efficiency and patient safety objectives tend to play equivalent roles.
- **Consumer Incentives:** Efforts are being launched to encourage consumers through reduced co-payments, deductibles, and/or premiums to use providers that are achieving quality performance.

VII. CONCLUSION

Thank you for the opportunity to testify on this important issue. Today's health care system is at a critical crossroads. We need to work on the three interrelated goals of controlling costs, improving quality, and expanding access. Progress on cost containment and quality improvement can free up resources to expand access to health care coverage for all Americans.

We applaud the subcommittee for focusing on value-based purchasing as an important step toward improving the quality, safety and efficiency of the U.S. health care system, and we look forward to working closely with you to achieve these goals.

Appendix A

SPECIFIC INITIATIVES FOR REWARDING QUALITY PERFORMANCE

To provide a better understanding of pay-for-performance initiatives in the private sector, we are providing brief examples of programs being implemented by our members across the country.

- **Aetna**has launched a network of specialist physicians who demonstrate effectiveness based on certain clinical measures, such as hospital readmission rates over a 30-day period, reduced rates of unexpected complications by hospitalized patients, and efficient use of health care resources. Consumers who choose these specialists benefit through lower co-payments, and providers benefit through increased patient volume. The Aexcel network, which is currently available in nine markets across the country, includes physicians in twelve medical specialties—cardiology, cardiothoracic surgery, gastroenterology, general surgery, obstetrics/gynecology, orthopedics, otolaryngology, neurology, neurosurgery, plastic surgery, vascular surgery, and urology.
- **CIGNA HealthCare of California** participates in the Integrated Healthcare Association's (IHA) quality incentive program. CIGNA rewards the top 50 percent of contracted physician groups for meeting each of the IHA clinical and member satisfaction metrics. Top-performing groups in all components of the Rewards Program are eligible to receive a minimum of $1.60 per member per month. Payment is based upon the total annual member months of the group's population. In the first year of the program, the payout in CaliforniaforIHA was $4 million.
- **Health Net of Connecticut** has entered into a partnership with the Connecticut State Medical Society-Individual Practice Association (CSMS–IPA) to establish a "P4Q" program that will reward eligible physicians for providing high quality, cost-effective care. The P4Q program, announced in July 2005, includes both primary care providers and specialists, providing them with an opportunity to earn bonus compensation beyond their current fee-for-service reimbursement. Diabetes treatment, breast cancer screenings and childhood immunizations are included among the areas where physicians will be rewarded for taking preemptive action. The first bonuses are expected to be paid out in the second quarter of 2006, based on performance measures for 2005.
- **HealthPartners** has implemented an Outcomes Recognition Program that offers annual bonuses to primary care clinics that achieve superior results in effectively promoting health and preventing disease. Since 1997, this program has awarded more than $3.95 million in bonuses to primary care groups that meet performance goals focusing on diabetes, coronary artery disease, tobacco cessation, generic prescribing, and consumer satisfaction.
- **Highmark Blue Cross Blue Shield** has adopted a Quality Incentive Payment System that rewards primary care physicians for demonstrating improvement in measures for preventive screenings, treatment of chronic conditions, and other quality and service issues. In the tenth year of the program (2003), more than $12 million in bonuses were paid to primary care physicians who exceeded the average performance measure on various indicators.
- **Independent Health** uses a Quality Management Incentive Award Program that involves a physician advisory group in developing performance targets for key issues such as patient satisfaction, emergency room utilization/access, office visits, breast and colorectal screening, immunizations, and treatment for diabetes and asthma. In addition to paying bonuses to physicians who exceed these targets, this program has documented significant improvements in clinical care for enrollees.

- **PacifiCare Health Systems** has developed a Quality Index® profile that uses clinical, service, and data indicators to rank medical groups. Enrollees pay lower co-payments for office visits if they select physicians from a "value network" of higher quality, lower cost providers. Additionally, PacifiCare's Quality Incentive Program incorporates a subset of the Quality Index® profile and has demonstrated an average improvement of 20 percent in 17 of 20 measures, with rewards to high performing physicians exceeding $15 million in the past three years.
- **WellPoint's** quality programs provide increased reimbursement to hospitals and physicians based, in part, on achieving improved quality measures. For example, hospitals selected for Anthem Blue Cross and Blue Shield's Coronary Services Centers program in Indiana, Kentucky, and Ohio must meet stringent clinical quality standards for patient care and outcomes for certain cardiac procedures. Anthem Blue Cross and Blue Shield of Virginia's Quality-in-Sights Hospital Incentive Program (QHIP) rewards hospitals for improvements in patient safety, patient health, and patient satisfaction. The 16 hospitals that participated in the first year of QHIP in 2004 are receiving a total of $6 million for actively working to implement nationally recognized care and safety practices that can save lives. Blue Cross of California has a comprehensive physician pay-for-performance program that paid $57 million in bonus payments to 134 medical groups based on quality criteria in 2003. Blue Cross of California also has a PPO Physician Quality and Incentive Program (PQIP) that allows more than 4,000 physicians insix countiesin the San Francisco areato receive financial bonuses for superior performance on clinical quality, service quality, and pharmacy measures.

Chairman JOHNSON. Thank you. Dr. Armstrong.

STATEMENT OF JOHN H. ARMSTRONG, M.D., MEMBER, BOARD OF TRUSTEES, AMERICAN MEDICAL ASSOCIATION

Dr. ARMSTRONG. Thank you, Chairman Johnson. My name is John Armstrong, I am a trustee of the American Medical Association and a practicing trauma critical care and general surgeon from Miami, Florida. The American Medical Association would like to commend you, Madam Chairman, on introduction of your bill, H.R. 3617, the Medicare Value-based Purchasing For Physician Services Act of 2005. We are grateful to you and Members of the Subcommittee for your leadership in recognizing the need to replace the current Medicare physician payment formula, the SGR, and provide appropriate incentives for improving quality of care for Medicare patients. We also appreciate your repeated efforts, Madam Chairman, with Chairman Thomas in pressing CMS to make administrative changes to the physician payment formula retroactive to 1996 that would help Congress lower the cost of enacting a new formula. We agree, and urge CMS to do so immediately.

Today we are here to discuss H.R. 3617, which is critical for ensuring continued quality of care and access to healthcare services for Medicare patients. The American Medical Association and its member physicians are staunchly committed to quality improvement. We have convened the Physician Consortium For Performance Improvement for the development of physician performance measures. As a result of these efforts, 24 of 36 measures for physician-care endorsed by the National Quality Forum were developed by the consortium. The CMS is also using measures developed by the consortium in demonstration projects on Pay For Performance authorized by the Medicare Modernization Act. In June, our house of delegates adopted Pay For Performance principles and guide-

lines. A number of the provisions in H.R. 3617 are consistent with these.

First, H.R. 3617 would repeal the fatally flawed SGR and provide positive updates for physicians that reflect increases in practice costs. We appreciate your recognition that value-based purchasing and the SGR are not compatible. Value-based purchasing may save dollars for the Medicare Program as a whole, but many of the measures ask physicians to deliver more care. This concept conflicts with the SGR, which penalizes physicians with payment cuts when volume increases exceed a target. Additional pay cuts would only exacerbate the projected 26-percent reduction in physician reimbursement over the next 6 years, beginning with the first of this coming year. A recent AMA survey shows that these cuts will impair patient access.

Second, H.R. 3617 would require evidence-based valid performance measures developed by the medical specialties in a transparent process. Third, the bill would mandate a volume growth study for physician services. This is important for carefully distinguishing between appropriate and inappropriate utilization of services. We are happy also to have the opportunity to offer suggestions for enhancement of H.R. 3617 and want to work further with the Subcommittee in this effort. We would strongly support a greater amount of time for transitioning to a value-based program for physician services. A ramp-up period in 2006, with a phase-in from 2007 through 2010, would allow for proper development of the program. Pilot testing prior to full implementation is essential. Medicare value-based purchasing for physician services is a completely new concept, and demonstration results with this type of system are currently not available. The CMS only began a limited demonstration in April that applies to large group practices, not a wide array of physician practices, and a demonstration mandated by the AMA is still under development.

Further, we urge the decisions about public reporting be deferred until there is full resolution of certain elements, such as risk adjustment, that could affect how information is reported. Inaccurately reported information could adversely impact access to care for vulnerable populations. This would undermine the goals of value-based purchasing and violate our physicians' oath, first do no harm. Patients are served only if they are provided accurate, relevant and user friendly information. We urge clarification that H.R. 3617 would require resource use efficiency measures to meet the same rigorous evidence-based standards that apply to other measures. All physician measures must be valid, evidence-based measures that improve quality of care.

To conclude, we emphasize that stable medical practice economics are essential for value-based purchasing. Physicians must have the financial ability to invest in tools and initiatives, such as information technology that are necessary for moving medicine forward and continually achieving the new levels of quality improvement envisioned by value-based purchasing programs. The American Medical Association was founded on the mission of serving patients and ensuring access to quality care. We look forward to working with the Subcommittee and Congress to make improvements in the Medicare Program that allow physicians to carry out that mission

in service to our patients. I thank you for the opportunity to be here today.

[The prepared statement of Dr. Armstrong follows:]

Statement of John H. Armstrong, M.D., Member, Board of Trustees, American Medical Association

The American Medical Association (AMA) appreciates the opportunity to provide our views today regarding H.R. 3617, Chairman Johnson's "Medicare Value-Based Purchasing for Physicians' Services Act of 2005," which now has 31 cosponsors. We would like to commend you, Madam Chairman, and Members of the Subcommittee, for all of your hard work and leadership in recognizing the fundamental need to replace the Medicare physician payment update formula and provide appropriate incentives for improving quality of care for Medicare patients.

A 4.4% Medicare physician pay cut is scheduled to become effective January 1, 2006, and is the first in a series of cuts expected over the next six years, totaling 26%. H.R. 3617 is crital for ensuring continued quality of care and long-term access to health care services for Medicare beneficiaries.

AMA COMMITMENT TO THE DEVELOPMENT OF EFFECTIVE QUALITY IMPROVEMENT PROGRAMS

The AMA has long been committed to quality improvement, and we have undertaken a number of initiatives to achieve this goal. The AMA has convened the Physician Consortium for Performance Improvement for the development of performance measurements and related quality activities. Consortium membership includes: (i) clinical experts representing more than 65 national medical specialty and state medical societies, and additional medical specialty societies continue to join the Consortium; (ii) experts in methodology; (iii) the Agency for Healthcare Research and Quality (AHRQ); (iv) the Centers for Medicare and Medicaid Services (CMS); (v) the Joint Commission on Accreditation of Healthcare Organizations—liaison member, and; (vi) the National Committee for Quality Assurance (NCQA)—liaison member.

The Consortium has grown to become the leading physician-sponsored initiative in the country in developing physician-level performance measures, and senior CMS officials have stated that CMS is looking to the Consortium to be the primary measure development body for physician level performance measures used by CMS for quality improvement and accountability purposes (*e.g.*, pay-for-performance). In fact, CMS is now using the measures developed by the Consortium in its large group practice demonstration project on pay-for-performance, and plans to use them in demonstration projects authorized by the *Medicare Prescription Drug, Improvement, and Modernization Act of 2003* (MMA). Once measures have been developed through the Consortium, they should be reviewed and endorsed in a transparent process by a multi-stakeholder organization, such as the National Quality Forum (NQF), as is required by H.R. 3617. In fact, the NQF recently endorsed 36 measures for outpatient care, 24 of which were developed by the Consortium.

In June of this year, the AMA House of Delegates also adopted comprehensive pay-for-performance principles and guidelines that address five broad aspects of pay-for-performance programs: (i) quality of care; (ii) the patient/physician relationship; (iii) voluntary participation; (iv) accurate data and fair reporting; and (v) fair and equitable program incentives. More specific guidelines are associated with each of the AMA pay-for-performance principles, and we provided these principles and guidelines to the Subcommittee at its July 21, 2005 hearing on value-based purchasing.

LEGISLATION TO ESTABLISH VALUE–BASED PURCHASING FOR PHYSICIANS'

SERVICES UNDER MEDICARE

AMA/Medical Specialty Conceptual Framework for a Phased Approach to Pay-For-Performance

The attached conceptual framework for a phased-in approach to a Medicare pay-for-performance program was as jointly developed by the AMA and over 70 medical organizations, and we believe it will be helpful in providing guidance as we work toward refinements of H.R. 3617. We are committed to working with the Subcommittee, Congress and the Administration to help develop a fair, ethical, patient-centered, and evidence-based Medicare pay-for-performance program.

The attached framework is the result of extensive work by organizations representing a wide variety of physician specialties. It is our belief that the only way

pay-for-performance will be successful in Medicare is if it recognizes the great diversity of physician practices in this country. Many medical specialty organizations have shared with Congress very detailed principles outlining the necessary elements for pay-for-performance to work effectively. This framework is not intended to supersede these important documents, but rather to highlight areas of consensus in medicine to provide you with our best sense of how Medicare might begin to implement pay-for-performance.

Provisions in H.R. 3617 that are Consistent with AMA Pay-for-Performance Principles and Guidelines

As discussed further below, the AMA strongly supports theprovision in H.R. 3617 that would repeal the current Medicare physician payment sustainable growth rate formula (SGR) and replace it with updates that reflect increases in medical practice costs. This would treat physicians similarly to other Medicare providers, such as hospitals, home health agencies and skilled nursing facilities. H.R. 3617 also would ensure that physicians receive a base payment update, while physicians achieving quality goals would receive a bonus payment, and we strongly support this provision as well. We are happy to work with the Subcommittee in working through the details of the timing sequence of these payments, while keeping in mind that all physician organizations should have equal opportunity to qualify for available bonus payments

In addition, the AMA greatly appreciates that a number of provisions in H.R. 3617 are consistent with key pay-for-performance principles and guidelines recently adopted by our House of Delegates. These provisions would: (i) require that evidence-based, valid performance measures be developed in a transparent process by the medical specialties and validated through a consensus-building organization involving multiple stakeholders, such as the Physician Consortium for Performance Improvement; (ii) require a phased-in approach to allow all physician specialties the opportunity to participate in the program; (iii) allow voluntary physician participation in the program; (iv) require performance measurement to be scored against both absolute values and relative improvements in those values; (v) require safeguards against patient de-selection, as well as measures that take into account patient non-compliance, and (vi) require the Secretary of HHS to educate physicians and beneficiaries about the value-based purchasing program.

We also applaud the fact that H.R. 3617 would require a payment update equal to the Medicare Economic Index (MEI) for new physicians for the year they are determined by the Secretary to be "new." In addition, the bill would require a physician volume growth study whereby HHS must annually report on physician volume growth, with recommendations for responding to inappropriate volume growth by service, specialty and region. (The Secretary of HHS would also review, over 5 years, improvement in quality and efficiency, access and fairness of implementation of program.) There are many reasons for growth in the volume of Medicare services, and without further study it is impossible to determine what volume growth is appropriate or inappropriate. Earlier this year, for example, Medicare officials announced that spending on Part A services is decreasing. This suggests that, as technological innovations advance, services are shifting from Part A to Part B, leading to appropriate volume growth on the Part B side. The volume growth study in H.R. 3617 is important for distinguishing between appropriate and inappropriate volume growth. If there is a problem with volume growth regarding a particular type of medical service, the AMA would look forward to working with Congress and the Administration to address it.

Factors to Consider for Improvement of H.R. 3617

Public Reporting

The AMA is concerned about public reporting. Potential, adverse affects of public reporting must be avoided. If not approached thoughtfully, public reporting can have unintentional adverse consequences for patients, including, for example, patient deselection in the case of those who, for a variety of reasons, are non-compliant. Further, health literacy may not be adequate to comprehend basic medical information. Thus, several critical issues that must be resolved before public reporting provisions can be implemented. There needs to be a method for ensuring that any publicly reported information is: (i) attributable to those involved in the care; (ii) appropriately risk-adjusted; and (iii) accurate, as well as relevant and helpful to the patient.

Moreover, with regard to public reporting, it is critical that physicians have the opportunity for prior review and appeal with regard to any data that is part of the public review process, and physician comments should be included with any publicly reported data. This is necessary to give an accurate and complete picture of what

is otherwise only a snapshot, and possibly skewed, view of the patient care provided by a physician.

We urge clarification of the provisions in H.R. 3617, however, that address the opportunity for prior review and appeal with comment. The bill contains a provision establishing an appeals process and allowing the opportunity for prior review and comment on information concerning whether the physician met performance objectives, with comments to be made public with the report. Yet, the bill prohibits administrative or judicial review of certain matters, including the development and computation of physician ratings, as well as the application of performance improvement standards and thresholds to physicians. These provisions (*e.g.*, those barring administrative and judicial review of the application of performance standards to physicians) may be in conflict with those allowing physician appeal and comment of whether they met performance objectives. Thus, we urge that H.R. 3617 make clear that physicians have the opportunity for prior review, appeal and comment on publicly reported data.

Pilot Testing

We urge that H.R. 3617 include a provision for pilot-testing of any value-based purchasing program prior to full implementation. Since value-based purchasing is a completely new concept with regard to Medicare payment for physicians' services, pilot testing is critical for determining whether this type of payment system achieves its intended purpose. Pilot tests would also help identify program "glitches" and any needed modifications. For example, we are concerned about the impact of a pay-for-performance program on patients in areas that are under-served or have a high-disease burden. Pilot testing could illuminate appropriate methods for ensuring access for these patients.

A limited demonstration project being conducted by CMS, *i.e.*, the Physician Group Practice Demonstration, began only in April of this year, and thus results from that demonstration will not be forthcoming for some time. Moreover, this demonstration only applies to large group practices and not to the wide array of physician practices across the country. In addition, CMS' Care Management Performance Demonstration, authorized by section 649 of the MMA, is still under development and has not yet begun. Thus, it is not clear when results from this demonstration will be available.

In addition to pilot testing by CMS, we believe the Agency for Healthcare Research and Quality could also play a valuable role in identifying best practices related to value-based purchasing. Evidence-basedresearch, coupled with CMS pilot tests, wouldhelp ensure that no unintended consequences arise from the application of this new concept in Medicare.

Measures of Efficiency

Measures of efficiency are another strong area of concern. Efficiency measures have the danger that the lowest-cost treatment will supersede the most appropriate care for an individual patient. We appreciate that H.R. 3617 requires that efficiency measures relating to clinical care meet the same high standards that apply to quality measures. Efficiency measures must be evidence-based, valid measures developed by the medical specialty societies in a transparent process.

We urge the following considerations, however, with regard to efficiency measures. There must be broad-based consensus regarding what constitutes appropriate levels of care before measuring for efficiency. In addition, *all* efficiency measures should be evidence-based. (The same is true for quality measures.) All measures must have a valid basis, with sufficient evidence to show that the measure will improve quality of care. Thus, H.R. 3617 should extend the evidence-based requirement to all measures, including efficiency measures that the bill designates as not relating to clinical care.

Risk Adjustment

Development of risk-adjustment techniques are of great concern to the physician community. A reliable method for risk-adjustment is critical. Without it, there will not be an adequate reflection of a physicians' performance. As we move toward developing a reliable risk-adjustment technique, physician organizations must be consulted and be integrally involved in the process. We caution, however, that the measure development process must remain within the domain of the multi-stakeholder organization (such as the Physician Consortium for Performance Improvement) and medical specialty societies, and the separate process for developing risk adjustment techniques should not interfere with measure development.

Phase-In of Value-Based Purchasing Program

In accordance with the pay-for-performance AMA/specialty society joint conceptual framework discussed above, the AMA urges a greater amount of time in transitioning to a value-based program for physicians' services. Under this framework, there would be: (i) a "ramp up" period in 2006; (ii) pay-for-reporting in 2007 through 2009 with regard to various levels of quality information and measures, and (iii) pay-for-performance in 2010.

This timeframe would allow for the development of evidence-based measures, as well as their validation and endorsement through the appropriate process. This is necessary so that each medical specialty has an opportunity to participate in the value-based program.

Administrative Costs

The AMA also urges that any value-based purchasing program ensure that physicians are not burdened with additional administrative costs, especially for information technology systems that are needed to participate in the program. As discussed above, physicians cannot continue to absorb unfunded government mandates, and value-based payments for participation in the program should not be undermined by administrative costs.

Other Critical Considerations

The AMA also wishes to raise overall factors to be considered as we move forward in developing value-based purchasing legislation for physicians: (i) the number of patients needed to achieve a statistically valid sample size, which is particularly important for purposes of determining how "billing units," as set forth under H.R. 3617, are ultimately defined; (ii) the desire to keep the data collection burden low, while at the same time maintaining accuracy of the data; (iii) level of scientific evidence needed in establishing appropriate measures; (iv) the ability to trace a performance measure back to one or many physicians involved in a patient's care; (v) the complexities of distributing payments when multiple physicians are involved in a patient's care, and without violating any fraud and abuse laws and regulations; and (vi) protection of patient privacy.

Finally, as we move forward in the development of value-based purchasing programs for physicians' services, care should be taken to review savings achieved in certain parts of the Medicare program due to these programs. In fact, AMA policy seeks to "ensure that any Medicare Part A savings which are achieved when physicians' efforts result in fewer in-patient complications, shorter lengths-of-stays, fewer hospital readmissions, etc., are ″credited″ and flow to the Part B physician payment pool."

We commend Chairman Johnson for your sensitivity to these important factors, and we look forward to working with you to achieve a new payment system for physicians that keeps pace with the cost of practicing medicine and rewards physicians for the quality of care they provide.

H.R. 3617 Recognizes the Need to Repeal the Current Medicare Physician Payment Sustainable Growth Rate Formula

The AMA applauds the Subcommittee's recognition that value-based purchasing is not compatible with the current fatally flawed SGR physician payment formula. We also strongly support the provision in H.R. 3617 that would repeal the SGR and replace it with updates that reflect increases in medical practice costs.

Specifically, H.R. 3617 would establish a 1.5% update in 2006. Thereafter, the update would be based on MEI, which is Medicare's index for measuring medical practice cost inflation. In 2007–08, the payment update would be based would MEI if certain performance reporting requirements are met. If not, the update would be MEI minus 1. In 2009 and subsequent years, the update would be MEI if reporting requirements and quality and efficiency measures are met. If not, the update would be MEI minus 1.

H.R. 3617 recognizes that the current Medicare physician payment system is not compatible with a value-based purchasing program for physicians. Value-based purchasing may save dollars for the Medicare program as a whole by reducing medical complications and hospitalizations. The majority of measures, however, such as those focused on prevention and chronic disease management, ask physicians to deliver more care. During his May 11, 2004 testimony before the House Ways and Means Health Subcommittee, CMS Administrator, Dr. Mark McClellan, suggested that one of the agency's quality improvement projects, the Chronic Care Improvement Project, ″may actually increase the amount of (patient-physician) contact through appropriate office visits with physicians.″

The SGR is a spending target that penalizes volume increases exceeding the target. If the SGR is retained, the so-called reward for physicians will be additional pay cuts. This is antithetical to the desired outcome of value-based purchasing and would only compound an ongoing serious problem.

The flaws in the SGR formula led to a 5.4% payment cut in 2002, and additional cuts in 2003 through 2005 were averted only after Congress intervened. Without Congressional and Administrative action, Medicare payments to physicians will be cut by 4.4%, beginning January 1, 2006. As discussed above, this is the first of a series of cuts that are projected by the Medicare Trustees over the next six years, totaling about 26%. If these cuts begin, on January 1, 2006, average physician payment rates will be less in 2006 than they were in 2001, despite substantial practice cost inflation. These reductions are not cuts in the rate of increase, but are actual cuts in the amount paid for each service. Physicians simply cannot absorb these draconian payment cuts and, unless Congress acts, physicians may be forced to avoid, discontinue or limit the provision of services to Medicare patients.

A recent AMA survey indicates that if significant Medicare pay cuts become effective beginning in 2006:

- More than a third of physicians (38%) plan to decrease the number of new Medicare patients they accept;
- More than half of physicians (54%)plan todefer the purchase of information technology, which is necessary to make value-based purchasing work;
- A majority of physicians (53%) will be less likely to participate in a Medicare Advantage plan; One-third (34%) of physicians whose practice serves a rural patient population will discontinue rural outreach services;
- One-third of physicians (34%) plan to discontinue nursing home visits if payments are cut in 2006. By the time the cuts end, half (50%) of physicians will have discontinued nursing home visits.

A physician access crisis is looming for Medicare patients. While the MMA brought beneficiaries important new benefits, these critical improvements must be supported by an adequate payment structure for physicians' services. There are already some signs that access is deteriorating. A MedPAC survey found that 22% of patients already have some problems finding a primary care physician and 27% report delays getting an appointment. **Physicians are the foundation of our nation's health care system. Continual cuts put Medicare patient access to physicians' services at risk. They also threaten to destabilize the Medicare program and create a ripple effect across other programs. Indeed, Medicare cuts jeopardize access to medical care for millions of our active duty military family members and military retirees because their TRICARE insurance ties its payment rates to Medicare.**

PROBLEMS WITH THE SUSTAINABLE GROWTH RATE

There are two fundamental problems with the SGR formula:

1. Payment updates under the SGR formula are tied to the gross domestic product, which bears little relationship to patients' health care needs or physicians' practice costs; and
2. Physicians are penalized with pay cuts when Medicare spending on physicians' services exceeds the SGR spending target, yet, the SGR is not adjusted to take into account many factors beyond physicians' control, including government policies, that although good for patients, promote Medicare spending on physicians' services.

CMS Administrator McClellan recently stated that the current system of paying physicians is simply not sustainable. We agree, and urge CMS to use its authority to take administrative action to help Congress avert physician pay cuts and ensure that a stable, reliable Medicare physician payment formula is in place for Medicare patients, as discussed below.

ADMINISTRATIVE ACTION NEEDED TO ASSIST CONGRESS IN REPLACING THE SGR

CMS has the Authority to Remove Drug from the SGR, Retroactive to 1996

The AMA extends its gratitude to Chairman Thomas and Subcommittee Chairman Johnson for your repeated efforts in pressing CMS to join forces with Congress to replace the flawed physician payment formula. As your letter to CMS Administrator McClellan, dated July 12, 2005, states: "A permanent legislative fix to the Sustainable Growth Rate (SGR) formula would be prohibitively expensive given current interpretation of the formula, but could proceed through our joint efforts combining administrative and legislative action." The letter also affirms CMS' authority

to remove the costs of drugs, back to the base period, from calculation of the SGR. **The AMA adamantly agrees with the Chairmen that CMS should retroactively remove drugs from the SGR, and we continue to join the Chairmen in urging CMS to do so for the 2006 physician payment rule.**

Recently Administrator McClellan testifiedthat removing drugs will not have any impact on physician payment updates under the SGR for at least several years. We believe that this statement is based on a scenario where drugs are removed going forward, rather than from the base-year forward. Nonetheless, under any scenario, removing drugs *will* significantly reduce the cost of legislation to address the looming Medicare pay cuts and CMS should take this step as soon as possible. Indeed, CMS told Congress earlier this year that removing drugs prospectively is worth about $36 billion, while removing them from the base-year forward is worth $111 billion.

CMS has the authority to remove physician-administered drugs from the SGR, retroactive to 1996. When CMS calculates actual Medicare spending on "physicians' services," it includes the costs of Medicare-covered prescription drugs administered in physicians' offices. CMS has excluded drugs from "physicians' services" for purposes of administering other Medicare physician payment provisions. Thus, removing drugs from the definition of "physicians' services" for purposes of calculating the SGR is a consistent reading of the Medicare statute. Drugs are not paid under the Medicare physician fee schedule, and it is illogical to include them in calculating the SGR.

Further, if CMS adopts a revised definition of "physicians' services" that excludes drugs, it can revise its SGR calculations going back to 1996 using its revised definition.

These revisions would not affect payment updates from previous years, but would only affect payment updates in future years. This recalculation would be similar, for example, to the recalculation of graduate medical education costs in a base year for purposes of setting future payment amounts. That recalculation was approved by the Supreme Court.

CMS Should Remove Drugs from the SGR

Drug expenditures are continuing to grow at a very rapid pace. Over the past 5 to 10 years, drug companies have revolutionized the treatment of cancer and many autoimmune diseases through the development of a new family of biopharmaceuticals that mimic compounds found within the body. Such achievements do not come without a price. Drug costs of $1,000 to $2,000 per patient per month are common and annual per patient costs were found to average $71,600 a year in one study.

In 2004 alone, six oncology drugs received FDA approval or expanded approval, and two others received approval in 2003. As Dr. McClellan noted in testimony earlier this year, spending for one recently-developed drug, Pegrilgrastim (Neulastra) totaled $518 million last year, more than double the 2003 total. This drug strengthens the immune systems of cancer patients receiving chemotherapy, thereby improving and extending the lives of many and potentially reducing hospital costs in the process.

While the bulk of all physician-administered drugs are used to treat cancer patients, other factors—such as a rise in the number of patients with compromised immune systems and the number of drug-resistant infections in the U.S—also have contributed to the rapid growth of drug expenditures. This growth has dwarfed that of the physician services the SGR was intended to include. Between the SGR's 1996 base year and 2004, the number of drugs included in the SGR pool rose from 363 to 445. Spending on physician-administered drugs over the same time period rose from $1.8 billion to $8.6 billion, an increase of 358% per beneficiary compared to an increase of only 61% per beneficiary for actual physicians' services. As a result, drugs have consumed an ever-increasing share of SGR dollars and have gone from 3.7% of the total in 1996 to 9.8% in 2004.

This lopsided growth lowers the SGR target for real physicians' services, and, according to the Congressional Budget Office, annual growth in the real target for physicians' services will be almost a half percentage point lower than it would be if drugs and lab tests were not counted in the SGR. As 10-year average GDP growth is only about 2%, even a half percent increase makes a big difference. Thus, including the costs of drugs in the SGR pool significantly increases the odds that Medicare spending on "physicians' services" will exceed the SGR target. Ironically, however, Medicare physician pay cuts (resulting from application of the SGR spending target) apply only to actual physicians' services, and not to physician-administered drugs, which are significant drivers of the payment cuts.

Medicare actuaries predict that drug spending growth will continue to significantly outpace spending on physicians' services for years to come. In 2003, MedPAC reported that there are 650 new drugs in the pipeline and that a large number of these drugs are likely to require administration by physicians. In addition, an October 2003 report in the *American Journal of Managed Care* identified 102 unique biopharmaceuticals in late development and predicted that nearly 60% of these will be administered in ambulatory settings. While about a third of the total are cancer drugs, the majority are for other illnesses and some 22 medical specialties are likely to be involved in their prescribing and administration.

The development of these life-altering drugs has been encouraged by various federal policies including streamlining of the drug approval process and increased funding for the National Institutes of Health. In fact, under the leadership of Dr. McClellan and this Administration, the NIH has made substantial progress toward its goal of wiping out cancer deaths by 2015 and much of that progress is tied to the development and more rapid diffusion of new drugs. The AMA shares and applauds these goals. **It is not equitable or realistic, however, to finance the cost of these drugs through cuts in payments to physicians, and thus these costs should be removed from calculations of the SGR.**

Government-Induced Increases in Spending on Physicians' Services should be Accurately Reflected in the SGR Target

The AMA agrees with Chairmen Thomas and Johnson, as stated in the July 12, 2005, letter referenced above, that CMS should take steps to ensure that the SGR accurately reflects spending increases due to such matters as expanded Medicare benefits and national coverage decisions.

As discussed above, the government encourages greater use of physician services through legislative actions, as well as a host of other regulatory decisions. These initiatives clearly are good for patients and, in theory, their impact on physician spending is recognized in the SGR target. In practice, however, many have either been ignored or undercounted in the target. Since the SGR is a cumulative system, erroneous estimates compound each year and create further deficits in Medicare spending on physicians' services.

Effective January 1, 2005, CMS implemented the following new or expanded Medicare benefits, some of which have been mandated by the MMA: (i) initial preventive physical examinations; (ii) diabetes screening tests, (iii) cardiovascular screening blood tests, including coverage of tests for cholesterol and other lipid or triglycerides levels, and other screening tests for other indications associated with cardiovascular disease or an elevated risk for that disease, (iv) coverage of routine costs of Category A clinical trials, and (v) additional ESRD codes on the list of telehealth services.

As a result of implementing a new Medicare benefit or expanding access to existing Medicare services, the above-mentioned provisions will increase Medicare spending on physicians' services. Such increased spending will occur due to the fact that new or increased benefits will trigger physician office visits, which, in turn, may trigger an array of other medically necessary services, including laboratory tests, to monitor or treat chronic conditions that might have otherwise gone undetected and untreated, including surgery for acute conditions.

CMS has not provided details of how its estimates are calculated, and certain questions remain. Further, CMS reportedly does consider multiple year impacts and cost of related services, but the agency has not provided any itemized descriptions of how the agency determines estimated costs. Without these details, it is impossible to judge the accuracy of CMS' law and regulation allowances. For example, in reviewing the 2004 utilization and spending data, we found that utilization per beneficiary of code G0101 for pelvic and breast exams to screen for breast or cervical cancer had increased 10% since 2003. Although this benefit was enacted in BBA 1997 eight years ago, clearly it is continuing to effect SGR expenditures as continued promotion of the benefit by both the government and beneficiary organizations prompt more beneficiaries to take advantage of it. Likewise, per beneficiary utilization of code G0105, colorectal cancer screening of a high-risk patient, also enacted in the BBA, was up 13%. These impacts should be taken into account in determining the 2004, 2005 SGRs and 2006 SGRs.

In addition, CMS recently announced that physicians will receive an increased payment as a result of additional paperwork burden that will be shifted to physicians in documenting patient need for power wheelchairs and scooters. These increased payments should be reflected in the SGR. Further, in its 2006 payment preview, CMS identified physical therapy as an area of rapid volume growth contributing to accelerated growth in 2004. The physical therapy community has identified a number of regulatory changes that likely encouraged that growth, and CMS

should examine the degree to which legislative and regulatory changes on the Part A side have led to a shift of services into outpatient settings where they are included in the SGR pool.

Spending due to all of the foregoing governmentinitiatives should be reflected in the SGR.

Medicare Physician Spending Due to National Coverage Decisions should be Reflected in the SGR

When establishing the SGR spending target for physicians' services, the law requires that impact on spending, due to changes in laws and regulations, be taken into account. The AMA believes that any changes in national Medicare coverage policy that are adopted by CMS pursuant to a formal *or informal* rulemaking, such as Program Memorandums or national coverage decisions, constitute a regulatory change as contemplated by the SGR law, and must also be taken into account for purposes of the spending target.

When the impact of regulatory changes for purposes of the SGR is not properly taken into account, physicians are forced to finance the cost of new benefits and other program changes through cuts in their payments. Not only is this precluded by the law, it is extremely inequitable and ultimately adversely impacts beneficiary access to important services.

CMS has expanded covered benefits through the adoption of more than 80 national coverage decisions (NCDs), including implantable cardioverter defibrillators, diagnostic tests and chemotherapy for cancer patients, carotid artery stents, cochlear implants, PET scans, and macular degeneration treatment. While every NCD does not significantly increase Medicare spending, taken together, even those with marginal impact contribute to rising utilization. CMS has stated its view that it would be very difficult to estimate any costs or savings associated with specific coverage decisions and that any adjustments would likely be small in magnitude and have little effect on future updates. **We disagree, and strongly believe that CMS should make these adjustments in its rulemaking for 2006. CMS already adjusts Medicare Advantage payments to account for NCDs, so it clearly is able to estimate their costs.**

Accordingly, CMS should ensure that the SGR reflects the impact on utilization and spending resulting from all national coverage decisions for purposes of the 2006 physician fee schedule rule.

The AMA appreciates the opportunity to provide our views to the Subcommittee on these important matters, and we look forward to working with the Subcommittee and CMS to develop a payment system for physicians that ensures quality for our patients and reflects the costs of practicing medicine.

ATTACHMENT—AMA TESTIMONY

2006 Ramp-up

Medicare Update: Total additional dollars allocated to fix the SGR at least equal to the amount required to provide a fee schedule update equal to the increase in the MEI.

Development Period

- Measure Development (ongoing)
- PFP Pilot Tests/Demos

2007 Pay for Reporting

Medicare Update: Total additional dollars allocated to fix the SGR and fund a pay for reporting program are at least equal to the amount required to provide a fee schedule update equal to the increase in the MEI. All physicians guaranteed a payment "floor" of positive updates.

Reporting basic quality information such as:

- Practice structure (e.g. functions of IT use—patient registries)
- Participation in patient safety programs/use of protocols (e.g. mark your site, time out)

Development Period

- Measure Development (ongoing)
- PFP Pilot Tests/Demos

2008–2009 Pay for Reporting/Pay for Participation

Medicare Update: Total additional dollars allocated to fix the SGR and fund a pay for reporting/pay for participation program are at least equal to the amount required to provide a fee schedule update equal to the increase in the MEI. All physicians guaranteed a payment "floor" of positive updates.

• Transition to participation in more advanced quality improvement programs and reporting of evidence-based quality measures. Quality performance data will be transmitted back to physicians for internal quality improvement purposes. This phase would also test the feasibility of collecting data and accurately measuring physician performance in preparation for PFP.

Development Period

• Measure Development (ongoing)
• PFP Pilot Tests/Demos

2010 Pay for Performance

Medicare Update: Pay for performance (PFP) provisions are triggered contingent on repeal of SGR formula. Long term solution must assure that sufficient dollars are allocated to allow for positive annual fee schedule updates linked to inflation and money to be set aside to fund the proposed PFP program. All physicians must be guaranteed a payment "floor" of positive updates.

• % of Medicare payment of physicians (all specialties) based on quality performance
• Program focus on continuous quality improvement
• Performance measured on evidence-based measures of process and/or outcomes with appropriate risk adjustment, valid sample size, etc..
• Any "efficiency measures" used are transparent, evidence based, and focus on clinical quality improvement
• Only after adequate safeguards are put in place to prevent unintended consequences such as patient de-selection is public reporting permitted
• HHS conducts studies on Medicare program savings resulting from Part B quality efforts

Chairman JOHNSON. Thank you very much to all of the panelists. Dr. Armstrong, we really have appreciated the leadership that the AMA has provided to the physician community in leading the discussion on Pay For Performance, and not only the AMA, but all of the specialty organizations have been very helpful both to us and to the administration in beginning to identify clinical quality standards. As to this issue of public reporting, which I think is terribly important, it doesn't happen for 3 years. I think you are absolutely right, by then we need to be assured that the risk adjustment to process is accurate and that the data is accurate. I thought Dr. Jevon's comment about his effort to have to clean up his data was very interesting. Ms. Ignagni, you and your organization have been excellent at data issues and integrating data, and the sort of extraordinary number of things happening in the data management world does give me hope that Pay For Performance will push ahead. Remember at first it is on reporting things that are much simpler; by the time we really get to paying for clinical performance, I think we should have incentivized the world to be much more—to clean up the data that we use and to have much better grasp of what is usable and what isn't. The bill does, of course, require that the data be accurate and widely respected and so on. So, I do—I wanted to acknowledge those issues because they are all very important. Dr. Jevon, I just wanted to briefly ask you, it sounds to me like the systems that you have been involved in give bonuses because then a physician can actually see this is $5,000,

whereas no matter what the percent is, it is hard to see what is going to be at the end of the year?

Dr. JEVON. Well, I mean, there are different options for physicians. I have certainly been in a lot of programs where 10 percent of what your—10 percent of your fees are withheld and you get back parts of that——

Chairman JOHNSON. Well, we are not going to get into that.

Dr. JEVON. All right. So, Bridges to Excellence is clearly a bonus program, it is above and beyond. You apply, and if you meet their qualifications and you can prove that you are doing better things in several different areas, then you receive a bonus based on each patient that you see that is involved in the program.

Chairman JOHNSON. But that might be an easy way to address the issue of reduced hospitalizations. So, at the end of the year you get a bonus based on performance.

Dr. JEVON. Based on performance——

Chairman JOHNSON. For the effective level of hospitalization versus your level of hospitalization.

Dr. JEVON. Right. I don't know of any programs now that exist based on that. I mean, what I would mention is that in our world, with the under 65 population we have had tremendous success developing management programs that go after our sickest patients, treat them intensively at home to prevent hospitalization. So, I think this is a huge area for Medicare, because you know, the saying among us is that the top 2 or 3 percent of your patients consume 50 percent of your costs. So, if you focus laser—use a laser like focus on those patients, you can take care of them better and keep them out of hospital.

Chairman JOHNSON. It does seem to me, knowing as little as we do in so many aspects of this, giving the administration the opportunity to use bonuses could be a very good thing because you a couple that with MEI and MEI minus for some of the more complicated situations at the beginning, and at least begin to learn something about it. There are some definable circumstances. Anyway, we will think about that, and anyone on the panel who wants to help us think about that, I would appreciate. Dr. Berenson, I really was excited by your testimony because repealing SGR is clearly what we have to do. While I think we can use Pay For Performance to do more than you think we can use it for, certainly site of service differentials we are beginning to identify as a terrible cancer in the system. The Specialty Hospital Movement did demonstrate that. The administration is doing some work on that, we are doing some work on that. Next year we are going to look at all the rehab reimbursements in all the sites and try to take on those areas. MedPAC is doing this too, where there are clear differentials based on site that are driving care. I think we can kind of handle that, at least I think we can move in that direction because it is definable.

There are two issues that I want to get your opinion on; one is, you know, we don't repeat will SGR and leave nothing there, we repeal the SGR, we put in place a Pay For Performance system that actually can have very powerful criteria. I mean, eventually it can have electronic health records is one of the things that we have to move toward and parse that out to make steps toward, as well

as clinical data and histories and things like that; but it does require that there be both focus and accountability on other spending increasing in the program. If you look at Herb Koone's letter about the 15-percent increase, you know, the physician portion of it, and especially the office visit portion of it, was not one of the biggies, the biggie was imaging. So,me of that imaging we know to be a good idea, some we know to be a bad idea; it is very hard from Washington to figure out what is good and what is bad and you have to be careful. But they are doing some sensible things. If you go in and get the patient all set up and take one body part and then you take successive body parts, well, you are not going to get paid as much for the other two.

They are doing some other things. There are some credentialling things we can do that—we are very positive in the mammogram area, although we were unable to pay accurately so in the end it was sort of catastrophic. So, any—but I think requiring accountability, you know, requiring focus on each of the other—therapy, physical therapy helps us to say, well, this is going too fast, why is it going too fast? Is it number of patients, is it number of—types of changes in treatment protocols. One of the reasons why this third proposal that we are making to allow CMS to use AMB is that a lot of times the intenser treatment pattern is keeping people out of hospitals, and if we punish the system for the volume going up in this volume-based SGR system, when actually system-wide it is cutting costs, then we are just nuts. So, I want to try to get over that hump through this, and then through this experience we can see exactly what we need to do. In the interim, the cost control mechanism in the bill is not only the Pay For Performance, which is modest, but also focusing on the other areas, and specifically being responsible for controlling cost increases. Now why is that not going to have any effect?

Dr. BERENSON. I guess I don't understand what constrains in the bill, what constrains physician spending once the update is tied to the MEI, what constrains the overall spending.

Chairman JOHNSON. There are two things. One is, a lot of the quality indicators will reflect a commitment to management and will be able to—remember—well, you probably wouldn't because I don't know why you would notice in this bill, but we do do profiling; so we do send that back to physicians about what resources they are using to accomplish their goal. So, when we look at quality indicators, you know, over time we will have the ability to say, you know, the outcome should be X, these are the things we know have to be done to include that outcome—to reach that outcome, but how come you are doing all these other things? Now you have to go good risk adjusters or you won't be able to deal with complex patients and all that stuff, but why can't that approach work?

Dr. BERENSON. Well, I guess on this one I am from Missouri. It sounds good. I remember going to a PPRC profiling conference in 1991 because we were—in anticipation of the volume performance standard there was a desire—and organized medicine was at the table and we are going to have clinical practice guidelines and we are going to do evidence-based everything. There was a whole full-day meeting on how profiling of physicians and feedback of in-

formation was going to then change practice patterns, and we are now 15 years later and that hasn't happened.

I am not a real expert in Pay For Performance technology, but from what I have seen, there is a big—well, from what I have seen we have pretty good confidence on the measures of underuse. I am looking again at the measures that Mark shared with us. We want orthopedists do give antibiotics before surgery and that is desirable. That has very little to do with what is going on out there, which is orthopedists trying to form their own hospitals, referring their patients, doing surgeries that may or may not be appropriate; and I guess I don't see the technology, the Pay For Performance technology that is going to affect that behavior.

Again, to use the example just before, you get a report card saying that you are a high user and you are not going to get a two percent bonus. That, to me, is insignificant compared to the basic incentive to do more surgery. Now you are an owner of the facility, so you are not only making money as the professional doing the procedure, but as the owner of the facility. To me, the Pay For Performance is well-intentioned, and good doctors might respond to it, and the ones we are having problems with will ignore it.

Chairman JOHNSON. Yes. You are absolutely right, this doesn't solve all the problems. I think the administration is taking some actions, I am not sure they are going to be enough. I hear what you are saying about specialty hospitals. I think, though, part of the problem is they payment of what is a hospital and what is a ambulatory surgery center. We will see what the administration does to sort that out and what impact that has. But that is right, Pay For Performance doesn't address that kind of manipulation of the system. But I think in combination with other things, site-specific differentials and in a sense specialty hospitals or site specific differentials, it does give us a critical tool without which we can't either reach higher quality or——

Dr. BERENSON. I am all for doing all of this, I just think that if we really focus on the various tools around dealing with volume, we get away from—I mean, to me there is two major flaws in the SGR, tying it to the GDP just makes no sense at all. Number two, it functions at a national level, so good guys are penalized and bad guys are rewarded when they generate volume.

The problem in volume right now, we all look at imaging; some of what MedPAC has suggested makes some sense to me, but fundamentally we are paying too much for advanced imaging, we are paying too much for an MRI when every medical group outs there wants to buy their own MRI. So, I believe there should be some authority for the more administrator to do—this was around a few years ago—inherent reasonableness tests to make some modification on prices when it is very clear that we are getting too much—that is what a value purchaser would do would assess are we getting enough MRIs for our patient population and would conclude we are getting plenty, let's try reducing the price somewhat and see what happens.

Clearly there need to be constraints on; there needs to be—you can't let a rogue administrator just pick and choose. But I think there needs to be more ability to pick these targets of opportunity and not have it have to come back to Congress and go through the

political drill of getting everybody to agree that this is a reasonable place to make some cuts. So, I am all for having the administrator having a target and having some flexibility to do some things within constraints to make that target, Pay For Performance can certainly be one of the tools; but again, it can't clearly be—I think pricing policy is what Medicare basically does, and there needs to be more flexibility to do some things outside of formulas, national formulas.

Chairman JOHNSON. Thank you very much. We may have a chance to talk again and see if we can refine some of these aspects of the bill. Mr. Stark.

Mr. STARK. Well, I just want to thank the panel, Dr. Berenson and Dr. Jevon, for their comments and what they have added to—I guess to clarify some of our confusion. I really don't want to add anything to what the witnesses have said. I think you all have interests which are clear, and I appreciate your interest in the problems that we have to solve to bring decent care to our beneficiaries. We have an impending vote, so I think this session will soon come to an end, and thank you very much all for being here.

Chairman JOHNSON. I thank the panel very much. If there is any concluding comment any one of you wants to make, I would be happy to hear it. Dr. Jevon, you were nodding your head vigorously as Dr. Berenson talked about some of the excess.

Dr. JEVON. It is very difficult. For me the issue is—you know, healthcare can be very local, and with national policy it is very frustrating for doctors. We have our own issues, each of us, wherever we practice, and I do think—if Medicare wants to be successful in controlling costs, they need to develop that flexibility and possibly give—develop programs that say to a region or to a group of doctors or a network of doctors, here are your goals, this is what we want.

Chairman JOHNSON. Well, that is very interesting. We will conclude the hearing, but you should know that there is a demonstration project that works that way with groups of physicians, and in the bill physicians have the right to be seen as one—a group to be seen as one and be accountable as one. So, that opens that avenue. Dr. Berenson.

Dr. BERENSON. I was just going to say, I love the group practice demo, I think it is terrific, and especially the opportunity to achieve savings in part A. My only caution is—and I know Mark talks about it a lot—is for groups of 200 or more, and that is not where a lot of the care is being provided. In fact, I had a chance yesterday to visit the one in Middletown, Connecticut, which I know you know about, and they have got an organization that can manage that kind of a situation. Most doctors are not in that kind of situation. I am all in favor of giving incentives for docs to form larger groups, but until we get there, I guess I am just a little skeptical about our ability to measure at the individual physician level, to make valid inferences about performance at the individual doctor level around not only—I mean, quality, we will need to develop the risk adjusters to make those inferences on quality, but about efficiency at the individual doctor level, I am quite skeptical about. I know there is this episode group that people are talking about which defines an episode of diabetes or congestive heart fail-

ure as 365 days, I am not quite sure what an episode that is. We are looking, I think, at capitation or something.

These are major issues, this is not just some tinkering with Pay For Performance. So, I think we are stuck as long as we have that form of practice—and a lot of Americans and a lot of doctors seem to prefer that form of practice—I think we are stuck with having to deal with some volume control mechanisms. In a fee-for-service system, the STR is lousy, so we need to go to some more targeted measures and provide some discretion for, I think, the administrator to go to those targets and not have to come back to Congress to get permission to do this and to do that.

Chairman JOHNSON. Ms. Ignagni.

Ms. IGNAGNI. Madam Chair, I know the time short so I will be very brief. I hope that as you engage in these deliberations, in addition to the how, you look at the what as well in terms of the data issues. They are significant. We think that there is a way to begin to look fairly from a physician perspective at a range of data as opposed to a small slice of patients, we think that is very, very are important.

Number two; if you look at the research, I think you come away with a strong sense that there is a real disconnect between the pace of development at the clinical trials level and the diffusion of the lag and diffusion into practice. So, we think there are—and clearly there isn't time to talk about all of this today, but this is one part of a larger strategy, and we would be delighted to offer more information on what the private sector is doing to inform the community. But at the same time, I think the work that has been done in this Committee, the thinking around arc and setting up a center for effective practices, we can get more information out there, all of those issues we think are very, very relevant. Then finally, on the disclosure piece, we think it is very important to begin to involve consumers and purchasers in those disclosure conversations in addition to physicians so that we can move forward in a way that everyone will find acceptable.

Chairman JOHNSON. Excuse me. I didn't realize we were voting, I don't have my beeper, so I hadn't noticed that we were voting. But thank you very much. I have 10 minutes left, so I do have to call it to an abrupt halt. Thank you very much.

[Whereupon, at 4:44 p.m., the hearing was adjourned.]

[Submissions for the record follow:]

California Medical Association
San Francisco, California 94105
September 29, 2005

The Honorable Chuck Grassley The Honorable Bill Thomas
The Honorable Max Baucus The Honorable Nancy Johnson

Dear Senators Grassley and Baucus and Representatives Thomas and Johnson:

This letter represents the work of leaders from California's physician, consumer, purchaser, payer and academic communities that are coming together to affirm the need to reform how Medicare measures, reports on and pays for physician services. The current payment system for health care is not working. A Medicare Value Purchasing program must be enacted and implemented now! We urge that Medicare lead reforms to advance a system which increasingly rewards physicians for providing the right care at the right time; supports prevention and ongoing care for the chronically ill; rewards both better performance and physicians who improve; and in which both physicians and patients have the tools and information necessary to ensure high-quality, appropriate care.

Our consensus on many of the core elements of a Medicare Value Purchasing program is unique in that it is anchored in our work in California where diverse stakeholders working together have improved care for patients and engaged physicians in quality improvement. One example of California's pioneering efforts can be found in the Integrated Healthcare Association's pay for performance program. Through this program multiple health plans and hundreds of physician groups representing over 35,000 physicians and serving over 6 million consumers have collaborated to develop a uniform measurement set and a single public report card. Millions of dollars have been paid in performance incentives and motivated significant quality improvements. As a result, patients are getting better, more effective care, and medical groups and physicians are being rewarded for performance improvement.

This letter addresses Congress' consideration of a variety of proposed Medicare payment reforms, such as proposed by Senators Grassley and Baucus, and Congresswoman Johnson. At the same time, there is appropriately significant attention being given to the need to provide support for the adoption of health care technology infrastructure that is directly linked to physicians' ability to optimize the quality of care delivered, improve patient experience and save costs by delivering care more effectively.

There are specific elements of each of the Medicare Value Purchasing proposals that we respectively support, oppose or believe do not go far enough. We agree, however, that moving to robust measurement, substantial performance-based payments and full public reporting should be done as rapidly as possible, while ensuring that they are done correctly and incrementally. Whether full implementation is completed in three or five years is far less important than that the process start immediately and move ahead in a way that effectively engages physicians and consumers. What follows is a description of our common vision and of the core elements regarding the measures, payments and public reporting that we believe should be part of any ultimate reform package.

Vision for Medicare Purchasing Reform

Medicare Value Purchasing is a necessary first step to creating a physician measurement, payment and reporting system designed to improve the quality, safety, effectiveness and efficiency of health care. In summary, as described in more detail below, the launch of this reform should include:

- **Measurement of Performance** that can be quickly implemented, by starting with measures currently in use, fairly adjusts for physicians' patient populations where appropriate, is centered on patients' needs and experiences, and is usable by physicians to improve the care they deliver;
- **Performance-Based Payments** as part of an overhaul of the annual physician fee schedule updates to base increases on the Medicare Economic Index (MEI). Performance-based payments should grow over time, becoming an increasingly substantial portion of physician payments, initially rewarding for agreement to participate, and then for both performance and improvement; and
- **Performance Reporting** that provides feedback to physicians on their own performance, with a progression to public reporting that provides as full and fair a picture as possible of physicians' performance and improvement.

Implementation must start now. These elements, while unto themselves major reforms for the current health care system, are but first steps. Next steps should include implementing parallel efforts for other health care providers and shifting the focus to measure and reward care for the whole person. For example, measurement, reporting and payment systems should increasingly consider all of patients' episodes of care, enhanced measures of care processes, actual health outcomes, end-of-life and palliative care, delivery of preventive services and coordination of care for the chronically ill.

Measurement of Performance

Due to the groundwork laid by medical professional societies, California's multistakeholder initiatives and other efforts over the past several years, there exist many quality of care measures that are objective, quantifiable and transparent. Medicare can build on these existing measures and foster the rapid development of new metrics for the full spectrum of patients' care needs and physicians' practices. Measurement principles for Medicare Value Purchasing include:

- Measures should build on existing measurement initiatives and measures currently widely used. The relatively limited number of measures available for immediate adoption need not delay implementation; rather, it can be part of the impetus for expanding available measures;

- Measures using administrative data and electronic medical records are preferred to minimize costs of collection;
- Measures should start with those easier to collect, building in a timeline for later adoption of outcome measures where possible. Examples of readily collected measures include process measures (e.g., the percentage of diabetes patients tested for blood sugar levels); structural capacity of physicians to provide high quality care (e.g., ability of physicians to identify and follow categories of patients or to adopt health information technology); and patient experience of care, using standardized and validated instruments and survey processes;
- Measures of efficiency that go beyond conventional utilization review and provide appropriate attribution to each member of the health care team to create a total ownership of health care concept which evaluates the relative use of resources, services and expenditures;
- New measures and increasingly comprehensive measure sets that assess prevalent and important (based on health status implications) conditions across all specialties need to be developed and submitted to consensus bodies for endorsement. Over time, increased attention should be given to measures of care coordination across providers and settings. Both physicians and consumers must be actively engaged in measure development and review processes; and
- Measures should reflect attributes that assure their acceptance by physicians and their reliability for patients. Attributes include their being evidence-based, subject to appropriate attestation, audit and confirmation, consistent, valid, not overly burdensome to collect, relevant to physicians and patients, fairly reflect physicians' patient population and are adjusted to assure there are little or no inappropriate patient selection or de-selection effects.

Performance-Based Payment

Payment based on performance is critical to Medicare physician payment reform. This would include replacing the current Sustainable Growth Rate (SGR) with the Medicare Economic Index (MEI), a portion of which would be set aside to reward each physician's participation, performance and improvement as appropriate. Specific elements of the payment system for Medicare Value Purchasing include:

- The portion of the funds allocated to performance-based payment should grow over time, and must eventually reach a substantial portion of a participating physician's pay, while keeping the overall program cost within the MEI. Performance-based payment to participating physicians should vary based upon their performance;
- Initially reward for agreeing to participate and share performance information; and then shift to rewarding performance (first compared to local peers and then national) and improvement; Payment designs that provide incentives for each medical specialty to ensure that robust sets of performance measures are rapidly adopted. Payments should be linked to the appropriateness and comprehensiveness of measure sets within specialties; Payment and/or measures are adjusted to ensure appropriate incentives for those who care for the sickest, or those with complex, chronic conditions; Payment and/or measures that encourage the adoption of care management processes or techniques; Payments for care based on new technologies reflect the extent to which they improve the quality of care and its cost-effectiveness; and Payments specifically integrate rewards for both total cost of health care impacted by physicians' actions and health care quality. As the payment system evolves, this consideration should specifically take into account savings generated—or additional costs incurred—related to prescription drugs and hospital services.

We believe that concerns of potential unintended consequences of moving too rapidly to increase the portion of physician payment that is performance-based are reasonable. However, we agree on the need to quickly increase performance-based payment because we recognize that payment today has its own unintended negative consequences. All too often payments today reward volume over quality, or care that is wasteful and inappropriate instead of patient-centered and efficient.

Performance Reporting

Providing performance information is critical to the goal of improving care delivery, both to the physicians themselves and to patients to enable them to be better engaged in their own health care. Specific elements of the performance reporting for Medicare Value Purchasing include:

- Before any information is made public, the physician (or whatever unit of delivery is measured) should receive their specific performance. Physicians should be

given actionable information from which they can improve and the opportunity to comment on concerns they have about the performance results;
- Public reporting should include all Medicare contracting physicians, with performance information occurring in a phased manner: initial reporting should positively identify participating physicians; then those who performed well or with marked improvement; and then full public reporting of both composite and all valid specific measures of all participating physicians; and
- Full background for any measures, their methodologies of measurement and adjustments for patient population should be publicly available to both physicians and the public.

Conclusion

We believe that the sooner a Medicare Value Purchasing program is implemented, the sooner we will be rewarding better care delivery and promoting the quality and value improvements we must expect. We appreciate your consideration of our thoughts.

Sincerely, [1]

Jack Lewin, MD
Executive Vice President and CEO
California Medical Association

Peter V. Lee, JD
President and CEO
Pacific Business Group on Health

Ron Bangasser, MD
Director of External Affairs
Beaver Medical Group
Former President—California Medical Association

Robert Margolis, MD
Chief Executive Officer
HealthCare Partners Medical Group
Chairman-Elect, National Committee on Quality Assurance (NCQA)

Bruce G. Bodaken
Chairman, President & CEO
Blue Shield of California

Arnold Milstein, MD
Medical Director
Pacific Business Group on Health

Donald Crane
President and CEO
California Association of Physician Groups

Jo Ellen H. Ross, MNA
President and CEO
Lumetra

Jarvio Grevious
Deputy Executive Officer, Benefits Administration
California Public Employees Retirement System

Stephen Shortell, PhD
Dean, School of Public Health
University of California, Berkeley

Jennie Chin Hanson
Board of Directors
American Association of Retired Persons (AARP)

Tom Williams
Executive Director
Integrated Healthcare Association (IHA)

[1] With the exception of signators from the California Medical Association, the California Association of Physician Organizations and the Pacific Business Group on Health, which have endorsed this consensus statement as organizations, the group affiliations of signators are listed for identification purposes.

Statement of Jack Ebeler, Alliance of Community Health Plans

The Alliance of Community Health Plans (ACHP) is pleased to have the opportunity to submit written testimony to the Health Subcommittee regarding the introduction of value-based purchasing strategies in Medicare. ACHP is a leadership organization of 14 non-profit and provider-sponsored health plans that are among America's best at delivering affordable, high-quality coverage and care to their communities. Our members seek to transform care by pursuing the six aims for quality health care set forth by the Institute of Medicine—health care that is safe, effective, patient-centered, timely, efficient and equitable. We proudly count among our membership six of the National Committee for Quality Assurance's highest quality Medicare plans in 2004.

ACHP member plans serve more than one million Medicare beneficiaries—about 20 percent of current Medicare Advantage members—and will expand their Medicare Advantage plan offerings with the introduction of Medicare Advantage-Prescription Drug Plans in 2006. ACHP supports the introduction of value-based purchasing strategies throughout the Medicare program. For value-based purchasing to promote the broadest range of high-quality options for beneficiaries, performance measures should be developed for all sectors of Medicare and quality-based payment incentives introduced for Medicare Advantage and fee for service.

ACHP and Health Care Quality

ACHP has a long legacy of leadership on quality improvement and was formed more than twenty years ago to help health plan leaders share best practices, learn and innovate. One of the earliest products of this collaboration was the creation of the Health Plan Employer Data and Information Set (HEDIS®), which has now become the standard for assessing health plan performance in the commercial and public sector. Through the National Committee for Quality Assurance (NCQA)—which today manages and updates the HEDIS® measurement process—employers, Medicare, Medicaid and other payers regularly monitor and evaluate health plan quality. The HEDIS® clinical quality reporting process, coupled with the CAHPS® survey of patient satisfaction, provide a vital and meaningful assessment of health plan performance for beneficiaries and for public and private payers.

In 1997, the Health Care Financing Administration (now the Centers for Medicare and Medicaid Services) began requiring all health plans participating in Medicare to collect and report on HEDIS® performance measures. Today, these measures include clinical service indicators such as cancer screening and the screening and control of heart disease and diabetes risk factors. To help Medicare beneficiaries make informed decisions about their health plan choices, CMS makes comparative information about plan performance on these measures available on-line through www.medicare.gov or in printed form on request from 1–800–MEDICARE.

New health plan measures are regularly developed by NCQA and added to the Medicare HEDIS® reporting requirements. In 2004, NCQA added colorectal cancer screening and osteoporosis measures. In 2006, NCQA will add health plan reporting measures to evaluate the appropriate use and monitoring of medication in the elderly—a timely addition given the introduction of Medicare's Part D prescription drug benefit.

Having led the way in establishing health plan performance measures, ACHP is committed to translating what we learn from these measures into quality improvement strategies. This work takes two forms. First, ACHP members regularly review their clinical quality and patient experience performance to identify areas for improvement and, through ACHP-sponsored programs, share strategies and best practices. Second, ACHP assesses the ways in which public policy can support high-quality care and advocates for policies that encourage quality improvement. Our learning sessions have included explorations of how and when plans can use pay-for-performance incentives to help drive quality improvements in specific health care settings and across multiple settings. Our policy agenda includes a commitment to helping Medicare link quality improvement and payment by promoting the creation of quality reporting and value-based purchasing strategies throughout Medicare.

Medicare Advantage and Fee-for-Service Performance Measurement

The earliest stages of performance measurement often begin with structural assessments such as whether an organization has a quality committee in place or information technology capacity. Performance measurement quickly progresses to "process" measures that assess whether some recommended process or service has occurred. For example, a process measure might assess whether patients with coronary artery disease are regularly screened for high cholesterol. More advanced measures, sometimes called "intermediate outcome" measures, evaluate the clinical

follow-up to process steps, such as whether those identified with high cholesterol had it brought under control.

Medicare Advantage. All local Medicare Advantage HMOs are required to report to CMS on various process and intermediate outcome performance measures, which assess whether clinical services were provided and whether those services helped control chronic disease risk factors. Process measures are often reportable from claims data. The more advanced intermediate measures, which capture information about patients' health status, often require access to patient medical records. Access to records is needed because information such as blood pressure readings and lab test results (to determine if cholesterol or blood sugar is controlled) are not recorded on claims. Health plans generally employ nursing staff to audit medical records and report this data. There are no incentives or bonuses linked to this reporting.

Hospitals. With the passage of the Medicare Modernization Act, hospitals that participate in Medicare were encouraged to voluntarily report to CMS on a discrete set of performance measures with the incentive of receiving of an additional 0.4 percent payment update for reporting. More than 98 percent of hospitals report and receive the payment incentive.

Physicians. Physicians do not currently report on quality measures and are not required nor offered incentives to report. However, several efforts, including the Ambulatory care Quality Alliance's (AQA) work, are underway to identify measures of physician performance. Many of these measures build on the HEDIS ® measure set used to assess plan performance. It is unclear what mechanisms will be used to collect several of the proposed measures that will likely require extraction and validation of data from medical records.

The chart below identifies the performance measures CMS requires of health plans, the voluntary measures reported by hospitals and the potential physician measures developed by the AQA.

Measure	Health Plan HEDIS Medicare Measures (REQUIRED)	Hospital Core/ Quality Alliance Measure Set (VOLUNTARY)	Ambulatory Quality Alliance Measure Set (PROPOSED)
Prevention Measures			
Controlling high blood pressure	**P**		
LDL screening	**P**		
Colorectal cancer screening	**P**		**P**
Breast cancer screening	**P**		**P**
Cervical cancer screening	*		**P**
Inquire about tobacco use			**P**
Medical assistance with smoking cessation /Advising smokers to quit	**P**	**PPP +**	**P**
Flu shot	**P**		*
Pneumonia vaccine	**P**	**P**	**P**
Osteoporosis			
Osteoporosis management	**P**		
Diabetes			
HbA1C tests	**P**		**P**
HbA1C management control	**P**		**P**

Measure	Health Plan HEDIS Medicare Measures (REQUIRED)	Hospital Core/ Quality Alliance Measure Set (VOLUNTARY)	Ambulatory Quality Alliance Measure Set (PROPOSED)
Blood pressure management for patients with diabetes			**P**
Lipid measurement for patients with diabetes	**P**		**P**
LDL cholesterol level for patients with diabetes	**P**		**P**
Eye exam for patients with diabetes	**P**		**P**
Monitoring for nephropathy	**P**		
Heart Attack/Coronary Artery Disease (CAD)			
Aspirin at arrival		**P**	
Aspirin prescribed at discharge		**P**	
Beta-blocker after MI/at arrival	**P**	**P**	**P**
Persistence of beta-blocker after MI/at discharge	**P**	**P**	**P**
Cholesterol management after acute cardiovascular event / for patients with CAD	**P**		**P**
ACE inhibitor for left ventricular systolic dysfunction		**P**	
Thrombolytic agent within 30 minutes of arrival		**P**	
PTCA (angioplasty) within 90 minutes of arrival		**P**	
Heart Failure			
ACE inhibitor prescribed(for left ventricular systolic dysfunction)		**P**	**P**
Left ventricular function assessment		**P**	**P**
Comprehensive discharge instructions		**P**	
Pneumonia			
Oxygenation assessment		**P**	
Initial antibiotic w/in 4 hours of arrival		**P**	

Measure	Health Plan HEDIS Medicare Measures (REQUIRED)	Hospital Core/ Quality Alliance Measure Set (VOLUNTARY)	Ambulatory Quality Alliance Measure Set (PROPOSED)
Blood culture before first antibiotic received		**P**	
Mental Illness			
Follow-up after hospitalization for mental illness	**P**		
Antidepressant medication management (acute phase)	**P**		**P**
Antidepressant medication for at least 6 months (continuation phase)	**P**		**P**
Asthma			
Use of appropriate medications	*		**P**
Asthma: long-term control medication prescribed			**P**
Customer Satisfaction			
Courteous and helpful office staff	**P**		
How well doctors communicate	**P**		
Getting care quickly	**P**		
Getting needed care	**P**		
Rating of all health care	**P**		
Rating of health plan	**P**		
Rating of personal doctor	**P**		
Rating of specialist seen most often	**P**		

+ The Hospital Quality Measures include three smoking cessation measures: one for heart attack patients; one for heart failure patients and one for pneumonia patients.
* Note: Data collected or proposed to be collected for non-Medicare eligible age groups.
The chart does not include four AQA prenatal and child-specific measures.

Value-based Purchasing

ACHP believes that value-based purchasing strategies are an essential means of raising the quality of all sectors of Medicare. We applaud the Subcommittee for its ongoing efforts to examine models for physician incentives. ACHP strongly supported the provision in the MMA, originally sponsored by former representative Jennifer Dunn (R–WA), calling for an Institute of Medicine study and report on appropriate measurement and payment incentives in Medicare. Given the state of measurement development and data collection processes, we share the assessment of the Medicare Payment Advisory Commission that health plans may be among the most logical places to begin using quality payment incentives because established measures are in place and already regularly collected. We believe that adopting value-based purchasing for Medicare Advantage plans would be an important initial step in moving Medicare toward a more performance-driven system, while also helping to inform the development of measures and mechanisms for using incentives with physicians, hospitals and other health care sectors. However, wherever the Subcommittee chooses to begin, it should quickly move to introduce value-based pur-

chasing strategies across the Medicare program so that beneficiaries are able to participate in a program that values and promotes quality regardless of how they choose to receive their care.

The principles ACHP has crafted to help inform the development of Medicare value-based purchasing are outlined below:

- Payment-for-performance should eventually apply to all Medicare providers, including fee-for-service and Medicare Advantage. Given health plans' long record of reporting on standardized measures of quality, it is reasonable to begin with Medicare Advantage plans, including HMOs and PPOs.
- Payment-for-performance incentives should be based upon standards of excellence and improvement and favor excellence. Measures to evaluate both fee-for-service Medicare and Medicare Advantage plans should be developed. In the interim, incentives should be based on existing measures, strongly favor clinical effectiveness and recognize patient experience.
- To ensure successful implementation and sustainability, pay-for-performance incentives should be financed with new resources.

Thank you for the opportunity to share our views. We look forward to working with the Subcommittee on this important issue.

Statement of EmCare, Inc., Dallas, Texas

The Vital and Unique Role of Emergency Medicine Physicians Must Be Considered in Any Performance Based Standards

Background on EmCare, Inc.:

EmCare, Inc. ("EmCare") is one of the nation's leading emergency medicine physician practice management organizations. Through its emergency medicine physicians, EmCare provides emergency care in over 300 hospitals throughout the country. These hospitals range from some of the larger urban hospitals with the highest volume emergency departments to the smaller community hospitals with relatively low patient volumes, all of which depend on EmCare's physicians to deliver high quality care. We appreciate the opportunity to submit comments to the Ways and Means Committee on the Medicare Value-Based Purchasing for Physicians Act

EmCare supports the congressional efforts which support the Medicare Value-Based Purchasing for Physicians Act and which will protect America's physicians from a reduction in reimbursement for services provided to Medicare patients. We strongly believe that the current Medicare Physician Fee Schedule methodology, which will result in a 4.3% payment cut for physicians in 2006 unless Congress acts to halt the reduction, will have a detrimental impact on all beneficiaries and their access to care. Because of EmCare's unique role in providing care to patients in emergencies, we are deeply and especially concerned about the impact of this reduction on those beneficiaries who depend on care received through hospital emergency departments.

The sustainable growth rate's reliance on the gross domestic product level under the Fee Schedule methodology bears little relation to physicians' actual practice expenses and, therefore, does not address the increases in practice expenses being experienced by physicians.

This is particularly true for emergency medicine physicians.

Increasingly large numbers of Medicare beneficiaries are receiving services from participating physicians, while the costs associated with professional liability insurance and pharmaceuticals have rapidly grown. In addition to these costs, emergency medicine physicians assume a disproportionate share of the costs related to furnishing uncompensated care. Emergency medicine physicians incur unique costs mandated by the Emergency Medical Treatment and Labor Act ("EMTALA"). The EMTALA mandate applies to all patients, not just Medicare beneficiaries. EmCare strongly supports access to emergency medical services regardless of a patient's ability to pay and we are dedicated to that principle every single day twenty-four hours a day.

Because of our unique circumstances and our physicians' delivery of medical care within the emergency department setting, we are very concerned that the existing Fee Schedule does not recognize the true costs associated with furnishing emergency medical services, due in part (but not completely) to the large percentage of uncompensated care furnished in hospital emergency departments. Due to the fact that the current Fee Schedule does not take this significant factor into account, it seriously

threatens the care furnished by hospital emergency departments, which provide *the* crucial safety net of health care for millions of patients.

The tragic consequences of Hurricanes Katrina and Rita have again revealed the critical importance of emergency medicine professionals to the nation's public health safety net. The nation's emergency medicine physicians responded heroically to the twin impacts of Katrina and Rita. Working in difficult conditions in hospitals and clinics as well as in makeshift care areas in public buildings and airports, these emergency health care providers furnished services to *all* patients who needed and sought care. While the water is being pumped out of New Orleans and other areas, local hospital emergency departments have continued to work tirelessly to handle the surge of cases from evacuees in addition to their regular emergency patient load.

As the Committee deliberates the Medicare Value-Based Purchasing for Physicians Act, we ask that you consider the extraordinary challenges and conditions faced by emergency medicine physicians. We outline below our suggestions of the factors that should be considered in establishing quality and efficiency measures for services furnished by emergency physicians

How to Measure and Reward Services Provided by Emergency Physicians

1. Access

- EMTALA mandates that emergency medicine physicians provide care to all patients regardless of ability to pay. This imposes significant monetary and administrative requirements that are unique to emergency physicians and hospital departments.
- Complete access of all patients to medical care in the emergency setting should be recognized by Congress as the primary factor for measuring emergency physicians' performance.

II. Core Measures

- The core measures used for the National Voluntary Hospital Reporting Initiative can be used as a proxy to measure emergency physicians' performance. Because these core measures currently apply only to hospitals, certain controls would need to be put in place to measure individual physicians. For example, a unique physician identifier can be used track the services provided by each physician.
- Only the core measures that apply to emergency medicine and are under the control of emergency medicine physicians should be used in developing quality and efficiency measures for emergency medicine physicians.

III. Unique Setting

- Emergency physicians deliver care in a unique setting. Typically, the physician does not have an existing relationship with the patient and full access to the patient's medical history.
- As a result, emergency physicians must make an immediate assessment of the patient's condition often based on limited information. The emergency physician has little or no contact with or responsibility for a patient's pre—and post-emergency care. This factor makes impossible a clear "outcomes" based standard for emergency physicians.

IV. Auditing

- Current standards already exist and are used to audit the metrics applicable to emergency medicine physicians.

Conclusion

As dramatically demonstrated by Hurricanes Katrina and Rita, emergency medicine physicians play a critical role in rendering care to all patients wherever and whenever such medical care is medically needed. For patients who lack health insurance, this provides a vital safety net. The hard lessons taught by Katrina and Rita show that the nation's emergency care system must be taken seriously and protected by policymakers and planners.

Consequently, we urge the Committee to take into account the factors discussed above, including, but not limited to, the significant level of uncompensated care furnished by emergency physicians as part of any pay-for-performance methodology which may be created by the Committee and the Congress.

Thank you for the opportunity to submit these comments.

Statement of Mary Griskewicz, Healthcare Information and Management Systems Society (HIMSS) Advocacy & Public Policy Steering Committee, Alexandria, Virginia

BACKGROUND:

Madame Chair, Congressman Stark, and distinguished members of the Subcommittee, I am honored to submit this statement for the record. My name is Mary Griskewicz and I have the pleasure of serving as the 2005–2006 Chair of the Healthcare Information and Management Systems Society (HIMSS) Advocacy & Public Policy Steering Committee. I live in Connecticut and work professionally for IDX Systems Corporation as a Program Manager, Corporate Strategy and Business Development.

HIMSS vision is to *advance the best use of information and management systems for the betterment of healthcare*.

On behalf of HIMSS and the thousands of professionals in the healthcare information technology community, we want to commend you and your Subcommittee for your leadership role in promoting initiatives that increase the use of information technology throughout the healthcare sector. In particular, Madame Chair, we know personally of your commitment to this cause as was reflected during your remarks at our congressional reception where you were presented with the 2003 HIMSS Advocacy Award.

HIMSS and our Healthcare IT community colleagues are thankful for your efforts to highlight our shared goal of utilizing a National Health Information Infrastructure (NHII) to seamlessly transmit electronic healthcare records (EHRs) to improve patient safety and healthcare quality.

As you are well aware, healthcare IT continues to take steps and move forward to address President Bush's call to establish electronic health records for most Americans within ten years. The federal government's support of the of the Office of the National Health Information Coordinator, Agency for Health care Quality and the governments efforts to coordinate public and private health IT efforts by developing strategies, contracting for studies, and funding prototypes and demonstrations to enable health IT and most recently the appointment of the members to the American Health Information Community board created by Secretary Leavitt. The recent findings of the September 14, 2005, RAND study indicate "Widespread adoption and effective use of electronic medical record systems (EMRs) and other health information technology (HIT) improvements could save the U.S. health system as much as $162 billion annually by greatly improving the way medical care is managed, greatly reducing preventable medical errors, lowering death rates from chronic disease, and reducing employee sick days". http://www.rand.org/health/

Federal law requires Medicare payments to physicians to be modified annually using a formula known as the sustainable growth rate (SGR). Because of flaws in the formula methodology, it has mandated physician fee schedule cuts in recent years; these cuts have been averted only by congressional short-term fixes. Absent additional, long-term congressional action by December 31, 2005, the SGR will continue to mandate physician fee schedule cuts of approximately 5% per year for the next five years. Congress must modify the sustainable growth rate formula to allow adequate payment to cover physician cost. In addition, Medicare is the largest single purchaser of healthcare and it needs to be restructured to incentivize providers to provide excellent care to beneficiaries.

We are pleased Madam Chair that you have recently introduced H.R. 3617, the *Medicare Value-Based Purchasing for Physicians' Act of 2005*, into the U.S. House of Representatives for consideration. The legislation has fifteen co-sponsors and was referred by the House Speaker to both the House Energy & Commerce and Ways & Means Committees for action.

Senators Charles Grassley (R–IA) and Max Baucus (D–MT), Chair and Ranking Minority Member respectively of the U.S. Senate Finance Committee, have introduced S. 1356, the *Medicare Value Purchasing Act of 2005*, into the United States Senate for consideration. This legislation is co-sponsored by four U.S. Senators and has been referred to the U.S. Senate Finance Committee for consideration.

The primary purpose of both pieces of legislation is to provide promote value-based purchasing for the Medicare program. While Senate bill S.1356 the *Medicare Value Purchasing Act of 2005* attempts to improve the Medicare reimbursement payment system to physicians without attempting to stem the declining reimbursement rates. The President of the American Academy of Family Physicians has said that "these new requirements on physicians will mean they face lower payments and additional costs. This is not a formula for improving health care quality."

The House bill, on the other hand, proposes to resolve the sustainable growth rate (SGR) dilemma and promote value-based performance by encouraging physicians to

electronically report medical quality indicators. The House bill focuses only on physician reimbursement. It is estimated that the cost of H.R. 3617 is $100 billion over 10 years just to solve physician reimbursement.

HIMSS Position:

- HIMSS believes that Medicare should play a leadership role in improvements in health care quality. Medicare is the largest single purchaser of health care, providing health care coverage to over 40 million Americans. Yet when the program was created back in the 1960's, it was structured so that providers received the same payment regardless of whether they provided excellent or substandard care to beneficiaries. It is time to make a dramatic, but necessary change to the payment system by aligning payment policies to encourage and support quality care.
- HIMSS supports H.R. 3617, the Medicare Value-Based Purchasing for Physicians' Act of 2005, because it supports both implementing value-based purchasing programs under Medicare that links a small portion of Medicare payment to the delivery of high quality healthcare and the need to develop a more sustainable reimbursement model.
- HIMSS strongly believes that the SGR dilemma and the value-based purchasing requirements need to be addressed in tandem because clinicians cannot continue to face declining reimbursements for Medicare patients.
- HIMSS strongly supports reimbursing physicians based on the quality of care they provide their patients.
- HIMSS believes that the Senate bill will probably increase doctors' costs in order to meet and report specific care standards, but it does not help them obtain the technology to meet these requirements. If doctors don't have the technology to participate in the reporting system, their reimbursement will be cut even further, which will hinder their ability to ever be able to afford the technology
- The Senate bill is limited to provisions that directly relate to quality improvement, value-based purchasing, data coordination, and health information technology, but does not address the SGR dilemma. However, the bill does acknowledge, through "Sense of the Senate" language, that the negative physician payment update needs to be addressed. This language points out the unsustainable nature of the SGR formula and the need to develop a more sustainable model that is more appropriate in controlling the volume of physician services provided. HIMSS is pleased that the Senate recognizes that this needs to be addressed.

CONCLUSION:

We believe that the passage of HR 3617 will help us reach our goal to incentivize providers of care accordingly supporting the Presidents goal of achieving a national electronic health record for most Americans. We have noted that, the interest and attention on health information has been heightened. More specifically the events surrounding the Katrina relief efforts have highlighted the need for an Electronic Health Record, and the need to provide continued incentives to the providers of care that would allow them to use the technologies that will support the adoption of the electronic health record.

HIMSS supports H.R. 3617 because it resolves the SGR issue for physicians and attempts to promote value-based purchasing. This legislation is solidly aligned with HIMSS Legislative Principles and recognizes the key role that information systems can have in improving the health of all.

HIMSS will promote passage of this legislation as part of its overall advocacy agenda.

As you proceed forward in the months and years ahead, the 17,000+ individual HIMSS members and over 275 corporate HIMSS members representing over 2,000,000 employees are committed to working with you and others to make our shared vision of the widespread adoption of information technology and management systems in the healthcare sector a reality.

Statement of Michele Johnson, Medical Group Management Association

Introduction

This statement is submitted on behalf of the Medical Group Management Association (MGMA) to the Ways and Means Health Subcommittee hearing entitled, "Value-Based Purchasing for Physicians under Medicare, *H.R. 3617*." MGMA rep-

resents 19,500 members who manage and lead more than 11,500 ambulatory medical offices in which more than 240,000 physicians provide medical care.

Problems with Current Method of Medicare Updates to Medicare Pratices

Currently, Medicare provides annual updates to physician reimbursement through the Sustainable Growth Rate (SGR). In January 2006, unless Congress acts to prevent the formula from taking effect, Medicare's "update" to physician services under the SGR will be a—4.4 percent cut. Chairman Johnson understands that the SGR is a fundamentally flawed and unreasonable method of calculating physician updates. Physician practices face the prospect of significant cuts in Medicare reimbursement year after year, while their overhead costs rise significantly. This is true only for physician practices; other segments of the health care system receive regular annual updates because they do not utilize the SGR formula. In 2006, Medicare Advantage plans, hospitals, nursing homes and home health providers will all receive positive updates to their reimbursement rates.

Medical group practices confront this looming 2006 cut within the context of their recent experience with Medicare reimbursement. Because Congress was unable to act in time, physicians received a 5.4 percent reduction in 2002. Congress recognized the threat to Medicare beneficiary access and stopped the SGR from further reducing physician reimbursement in 2003, 2004 and 2005. While this was a relief to physician practices, these increases did not come close to keeping pace with the increase in medical costs. Because the SGR is not an accurate methodology for updating physician reimbursement annually, the Medicare Payment Advisory Committee has repeatedly recommended to Congress that the SGR be statutorily replaced with the Medicare Economic Index (MEI). The MEI is a price index, calculated by CMS, which more accurately reflects the costs of delivering medical care in physicians' offices.

MGMA has preformed cost surveys of medical practices for over 50 years. MGMA data indicates that the cost of operating a group practice rose by an average 4.8 percent per year over the last 10 years. In fact, between 2001 and 2003, MGMA data show that operating costs increased more than 10.9 percent. However, in this same timeframe, Medicare physician payment rates increased between 1.5 to 1.6 percent. This means that increases in Medicare reimbursement have already failed to keep pace with the rate of inflation in practice costs as calculated by the MEI or by the MGMA's cost survey data. The Medicare Board of Trustees estimates that the cost of providing medical care will increase by an estimated 15 percent over the next six years, while current reimbursement levels are scheduled to drop by an estimated 26 percent.

The chart below compares the recent annual increases under the SGR formula with the increase in medical operating expenses as calculated under the MEI and MGMA's own cost survey data.

Comparisons of SGR Updates with Calculations of Actual Increases in Medical Practice Operating Expenses

Year	*Increase in Medicare reimbursement under SGR*	*Medicare Economic Index (MEI)*	*MGMA cost survey data*
2002	-5.4 %	2.9%	7.5%
2003	1.6%	3.2%	3.2%
2004	1.5%	3.1%	Date not available
2005	1.5%	2.9%	Data not available

H.R. 3617 Repeal of SGR

MGMA supports Chairman Johnson's *H.R. 3617*, the Value-Based Purchasing for Physicians bill because it envisions significant reform to Medicare's physician reimbursement methodology. MGMA believes the bill demonstrates an awareness that physicians must be adequately reimbursed for the services that they deliver. MGMA concurs with the intent of the legislation to create a link between quality improvement based on evidence-based performance measures and full annual updates.

American College of Obstetricians and Gynecologists
Washington, DC 20024
September 29, 2005

The Honorable Nancy Johnson
Chair, Health Subcommittee
Ways and Means Committee
1136 Longworth House Office Building
Washington, DC 20515

Dear Mrs. Johnson:

On behalf of the American College of Obstetricians and Gynecologists (ACOG), representing 49,000 physicians and partners in women's health, thank you for the extraordinary leadership and commitment you've shown in your effort to correct a serious problem in the Medicare program by repealing the flawed Sustainable Growth Rate (SGR) formula and putting in place a system that works for physicians, and helps ensure access to high-quality care for our patients. Your legislation, H.R. 3617, the Medicare Value-Based Purchasing for Physicians' Services Act of 2005, has our full support.

ACOG has long been dedicated to maintaining the quality of care provided by obstetricians and gynecologists and has a robust ongoing process where we provide women's health physicians and providers with current quality information on the practice of obstetrics and gynecology. For nearly two decades, ACOG's Committee on Quality Improvement and Patient Safety has regularly reviewed practice and patient safety issues and encouraged our members to incorporate ACOG's recommendations into their practices. ACOG's Practice Committees regularly publish practice guidelines developed by committees of experts and reviewed by leaders in our specialty and the College. Each of these guidelines is reviewed periodically and reaffirmed, updated, or withdrawn based on new clinical evidence to ensure continued appropriateness to practice.

In 2004, in cooperation with the American Board of Obstetrics and Gynecology (ABOG), an independent, non-profit organization that certifies obstetricians and gynecologists in the United States, ACOG created Road to Maintaining Excellence, an initiative to allow ob-gyns to evaluate their own practice activities, reinforce best practices and assist in improving others. Currently in pilot stages, Road to Maintaining Excellence will require ACOG Fellows to complete questionnaire-based modules that focus on a single aspect of clinical practice, like prevention of early-onset group B Streptococcal disease in newborns and prevention of deep vein thrombosis and pulmonary embolism. As Fellows complete each module, data will be summarized and compiled by ACOG, and periodically reported to our members. Road to Maintaining Excellence will provide Fellows with valuable information about how their practice patterns compare to those of their colleagues but is not intended to be used as a performance measurement set or as a basis for payment.

ACOG has been working collaboratively with our primary care colleagues, as well as our colleagues in specialty and surgical care, to be supportive of moving toward value-based physician payments, linked with fixing the SGR. As Congress moves forward in establishing quality incentives in Medicare, ACOG believes that certain principles should be kept in mind, many of which are reflected in your discussions of pay-for-performance and your draft legislation.

- All physicians should receive a positive Medicare payment update as a floor for additional reporting or performance incentives. Under the current SGR formula, physicians will receive unsustainable payment cuts of nearly 30 percent over the next six years. Some performance measures may involve additional office visits, lab tests, imaging exams or other physician interventions that would only exacerbate the current volume formula. Physicians must not be penalized for any volume increase resulting from compliance with performance measures. To ensure an equitable accounting of the costs and savings generated from pay-for-performance, Medicare should account for savings to Part A generated by Part B performance improvements.
- The new payment system should be phased in, beginning with an administratively simple "pay-for-reporting" period that provides information about the quality and safety processes physicians are engaged in and assesses the availability of health information technology. Quality and safety process measures used in the Medicare system should have widespread acceptance in the medical community. One such process measure in obstetrics could involve use of a prenatal flowsheet, a performance tool developed by ACOG that was recommended

for use by an ACOG-led prenatal workgroup of the American Medical Association's Physician Consortium for Performance Improvement. In ob-gyn surgery, ACOG supports the procedural measures laid out in the first phase of the American College of Surgeons Framework for Surgical Care, including confirmation of operative site and side marking, pre-operative "time out," immediate post-operative documentation, post-operative pain management and appropriate post-operative care.

- Clinical performance measures should be developed by each specialty in a transparent process that considers scientific evidence, expert opinion and administrative feasibility of each measure. Measures should be appropriately risk-adjusted to account for a variety of factors, including patient compliance and complexity. Increased quality should be the goal of efficiency measures, and these measures, too, should be driven by data-based clinical evidence and expert opinion when data are lacking.
- Health information technology is prohibitively expensive for some small practices, particularly for the 23 percent of ob-gyns in solo practice, but is a necessary efficiency and a vital component of pay-for-performance. Acquisition of this technology should be encouraged with federal financial assistance for the purchase of hardware and software and for system training. National standards for health information technology would facilitate physician adoption of these systems, by reassuring physicians that the technology they invest in would not become obsolete. Because use of health information technology may be among the elements of the early "pay-for-reporting" system, it is vital that these steps be taken promptly.
- Congress needs to address the universe of legal issues surrounding data reporting. Information collected by CMS must be protected from use in medical liability litigation against physicians or as a basis for negligent hiring or retention claims. This may necessitate specifically exempting physician data from Freedom of Information Act requests. Care should be taken to avoid other unintended and unfortunate consequences of public data reporting, such as physician selection of patients with the fewest medical risk factors or the best history of compliance with instructions. This is essential to ensure continued access to care for low-income and minority populations who tend to enter the health care system at an acute stage of disease and illness and suffer worse outcomes regardless of the quality of care they receive.

We recognize the challenges in creating a quality improvement program for Medicare that leads us to meaningful clinical measures and improved quality for beneficiaries. We applaud your leadership and your commitment to this effort and we sincerely thank you for your willingness to work cooperatively with ACOG and the medical community in these important discussions. ACOG stands ready to work with you as we embark on this historic change in Medicare.

Sincerely,

Michael T. Mennuti, MD
President

Statement of the American Physical Therapy Association, Alexandria, Virginia

The American Physical Therapy Association (APTA) appreciates the efforts of the House Committee on Ways and Means and its Subcommittee on Health to improve the delivery of health care, especially your focus on quality care for seniors and persons with disabilities. The transition to a payment system for high quality, efficient health care services is vitally important to the beneficiaries that physical therapists serve under the Medicare program. APTA endorses and supports **HR 3617, the Medicare Value-Based Purchasing for Physicians' Services Act of 2005. While we support HR 3617**, we encourage the Committee to address all of the inadequacies in the current payment system in conjunction with its action on this legislation.

Elimination of the Flawed Sustainable Growth Rate (SGR) Methodology Prior to Moving Forward with Value-Based Purchasing for Health Professionals' Services:

HR 3617 eliminates the flaws of the existing system that determines Medicare payments to physical therapists and other providers under the Part B physician fee schedule, as well as improving the program's long-term solvency by creating incen-

tives to improve the quality of care provided to the nation's seniors and persons with disabilities. We are concerned that any effort to proceed with the transition to value-based purchasing or "pay for performance" without also addressing underlying flaws in the outpatient payment of physical therapy services would be inefficient and would ultimately erode the purpose of this legislation. By repealing the Sustainable Growth Rate (SGR) and replacing it with the Medicare Economic Index (MEI), the MedicareValue-Based Purchasing for Physicians' Services Act of 2005 (HR 3617) resolves one of the current payment inadequacies under Medicare Part B, and APTA commends Chairwoman Johnson and the Committee for addressing this critical payment issue.

Therapy Caps' Inconsistency with Value-Based Purchasing for Physical Therapists' Services under Medicare:

The pending restoration of financial caps on outpatient physical therapy services under Medicare threatens to limit this legislation's ability to fully achieve its objective. Congress must address the arbitrary caps placed on outpatient physical therapy services by the Balanced Budget Act of 1997 prior to transitioning to a valued-based system. If the therapy caps are not repealed, the effect of HR 3617 would be the application of two different payment systems to rehabilitation services at the same time: one system that pays for quality, efficiency, and improved outcomes in clinical practice implemented on top of another that arbitrarily caps beneficiary coverage that is based upon the former paradigm of volume and utilization. The implementation of an arbitrary financial limit is inconsistent with the goals represented by a value-based purchasing system. The objective of HR 3617 is the transition to a payment system that rewards quality, outcomes, and efficiency in clinical practice; arbitrary caps on services undermine and erode this objective. APTA stands ready to work with you and your Committee to address the therapy caps and incorporate value-based purchasing into the solution for this issue.

Inclusion of Non-Physician Providers in the Medicare Value-Based Purchasing for Physicians' Services Act of 2005 (HR 3617):

It is our understanding that your legislation is intended to include physical therapists practicing in outpatient settings, but we would encourage you to specifically reference physical therapists as participants in the development and attainment of clinically appropriate processes and measures to enhance the quality of rehabilitation care. We strongly encourage the inclusion of non-physician providers in the value-based purchasing discussions conducted by this committee and CMS. In the 2006 Medicare Physician Fee Schedule proposed rule, CMS discusses its current involvement with the physician community in developing useful quality measures and understanding overall trends. Although we are pleased to see that CMS is willing to work collaboratively with physicians to develop quality measures, we strongly urge CMS and this committee to also include physical therapists and other non-physician groups in these discussions. There are more than 120,000 physical therapists in the United States, many of whom provide services to Medicare beneficiaries and would be able to provide useful information regarding appropriate quality measures for physical therapy services. CMS has indicated that 3,747,395 Medicare beneficiaries (9.3%) accessed outpatient therapy services in CY 2002, resulting in expenditures of $3,392,226,958 for the Medicare program, which accounts for 2.3% of all Medicare Part B expenditures during that year. Although the annual per-patient expenditure for PT services is only $760, 88% of the recipients of Medicare-covered rehabilitation receive physical therapy specifically, totaling $2.54 billion and accounting for 75% of the total costs of all outpatient rehabilitation services combined. These numbers clearly indicate that physical therapy is an essential outpatient benefit that should be incorporated into any transition to value-based purchasing for physicians and other health care professionals.

Standardizationof a Consistent and Uniform Benefit for Physical Therapist Services in All PartB Settings:

APTA believes that the fragmentation of rules and regulations across the multiple settings in which physical therapists provide services to Medicare beneficiaries creates serious problems for a uniform and consistent value-based purchasing payment system. Currently, physical therapists provide outpatient services in eight (8) Part B settings, each governed by different requirements regarding supervision, certification of plans of care, and billing authority. APTA believes that value-based purchasing would be enhanced and provider accountability increased by moving physical therapy to a uniform part B benefit similar to the physical therapist in private practice (PTPP) benefit, which improves accountability with individual provider numbers for each licensed physical therapist, similar to physician providers. We would welcome the opportunity to simplify the Part B physical therapy benefit by

eliminating the fragmentation of physical therapy services across all Part B settings.

APTA's Efforts to Support Value-Based Purchasing for Physical Therapists Services: A Foundation for Pay for Performance in Therapy Services:

APTA believes that physical therapist practice is congruent with this initiative due to its focus on measurable outcomes of function, movement, and activities of daily living. We support reforming the Medicare payment system to reward providers for meeting clinically appropriate benchmarksto promote quality and improve the health outcomes of the Medicare population. APTA has been actively engaged in several initiatives to expand the utilization of health information technology and outcome measures that would lead to quality improvements in the provision of physical therapy services as well as to an effective value-based purchasing system for this essential service to Medicare beneficiaries.

To achieve these objectives, APTA has developed a specialized point-of-care electronic patient record system (CONNECT) designed for use by physical therapists, and a patient self-report instrument, the Outpatient Physical Therapy Improvement in Movement and Assessment Log (OPTIMAL) which documents the outcomes of physical therapist treatment. Specifically, OPTIMAL provides an outcome measure of the patient's functional status related to changes in movement. The patient uses OPTIMAL at the initiation of treatment and at discharge to indicate the level of difficulty experienced in performing 21 actions (e.g. rolling over, sitting, standing, bending, reaching, etc.) and the level of self-confidence in the ability to perform them. We firmly believe that OPTIMAL will be a valuable instrument in a pay-for-performance system. CONNECT enables practices to document the performance of a physical therapist in a particular practice and benchmark that performance with other clinicians. APTA would be happy to share the data derived from CONNECT with CMS so that it may be used to develop quality measures for a pay-for-performance system. APTA's ultimate objective is to develop a national outcomes database that will enable the profession to determine the effectiveness of physical therapist practice and to provide quality measures to assist payers such as Medicare shift to payment systems that reward quality. We believe our efforts are consistent with the objectives that your legislation outlines and should assist the Centers for Medicare and Medicaid Services (CMS) in developing and implementing quality measures for physical therapists of the kind envisioned by your legislation.

Recognizing the need for evidence-based practice, APTA also initiated a project several years ago referred to as "Hooked on Evidence," which involved the creation of a website dedicated to literature review on physical therapy efficacy. Specifically, APTA's Hooked on Evidence Website consists of a database of current evidence on the effectiveness of physical therapy interventions drawn from scientific research literature. The website allows physical therapists to search a database of extractions from peer-reviewed literature relevant to physical therapy, which has been aggregated to produce research-based guidelines for clinical practice.

APTA has also developed the *Guide to Physical Therapist Practice* ("the Guide"), which helps physical therapists analyze their patient/client management and describe the scope of their practice. The *Guide* delineates tests and measures and the interventions that are used in physical therapist practice. It also identifies preferred practice patterns that will help physical therapists (a) improve quality of care, (b) enhance positive outcomes of physical therapist services, c) enhance patient/client satisfaction, (d) promote appropriate utilization of health care services, e) increase efficiency and reduce unwarranted variation in the provision of services, and f) diminish the economic burden of disablement through prevention and the promotion of health, wellness, and fitness. Through the development of a health information technology infrastructure that supports quality improvement by providing physical therapists with tools to support evidence-based clinical decision making and incorporate performance measurement in their practices, APTA is helping to lay the groundwork for Medicare pay—for-performance.

Conclusion:

In summary, we recommend the following principles to enhance the H.R. 3617, the Medicare Value-Based Purchasing for Physicians' Services Act of 2005:

- Maintain the repeal of the Substantial Growth Rate (SGR) and its replacement with the Medicare Economic Index (MEI) in HR 3617.
- Eliminate the arbitrary therapy caps for physical therapists, occupational therapists, and speech language pathologists. If value-based purchasing rewards high quality, efficient, and clinically appropriate care, implementation of the therapy caps would unnecessarily limit essential benefits for our seniors and persons with disabilities, and would ultimately lead to increased costs in other areas.

- Include non-physician providers explicitly as part of value-based purchasing under Medicare. Physical therapists are paid according to the same fee schedule as physician providers and should be included in this new payment framework.
- Standardize the Part B benefit regarding physical therapy services.
- Utilize the foundation established by APTA to assist CMS in the transition of outpatient physical therapy to value-based purchasing.

We appreciate your sensitivity to concerns about the capability of all providers to become eligible for incentives and the need to eliminate current payment problems before attempting to create this new system. We also have questions about how CMS will select and implement reporting requirements and assessment measures. We look forward to working with you in addressing these and other issues as the House considers this legislation and other Medicare issues this fall. APTA is eager to work with you and your staff to ensure that legislation creating new structures in the Medicare program to provide incentives for reporting and transitioning to value-based purchasing is enacted in a fashion that ensures appropriate beneficiary access to care, reduces the administrative burden on both patients and providers, and improves the quality of care for all Medicare beneficiaries.

Statement of Steven Wojcik, National Business Group on Health

Congress Should Implement Medicare Pay-For-Performance Now

Issue: Congress is considering legislation that would implement value-based purchasing, or pay-for-performance, on a program-wide basis in Medicare. Pay-for-performance programs reward health care providers for quality care and efficiency through higher reimbursement and payments.

Too often, payment for health care is made without regard to whether services are needed or how well they are performed. While cost is tied to quality or performance in most other industries, in health care, including in Medicare, the opposite tends to happen—we end up paying more for poor service and the additional health care needed to "correct" poor quality.

The pay-for-performance movement continues to rapidly expand in the marketplace. In recent years, employers and other health care purchasers have developed and adopted payment programs to reward quality and efficiency in the health care system. For example, several of the Business Group's employer members participate in Bridges to Excellence and the pay-for-performance program of the Integrated Healthcare Association, two of the leading movements. Today, most large insurers and health plans have a provider incentive program. The Medicare program has several pay-for-performance demonstrations underway.

Pay-for-performance promises to advance evidence-based medicine, improve the quality of health care and the health of Medicare beneficiaries, which translates into better value for the Medicare program.

Position: The National Business Group on Health, a member organization of over 240 primarily large employers who provide coverage for 50 million Americans, strongly urges Congress to pass legislation that would implement pay-for-performance on a widespread basis in the Medicare program for hospitals, physicians, and other health care facilities and professionals. Pay-for-performance in Medicare would harness the government's leverage as the largest purchaser of health care in the U.S. to improve the quality and efficiency of Medicare and the overall health care system.

The Business Group believes that a Medicare pay-for-performance program should include the following:

- The performance measures adopted by Medicare should be measures developed by nationally recognized quality measurement organizations, such as the National Committee for Quality Assurance (NCQA), researchers, and practitioner groups that have been vetted and recommended by consensus-building organizations that represent diverse stakeholders, such as the National Quality Forum (NQF).
- Rewarding quality is paramount but rewarding quality care that is provided efficiently is also important and should be an essential part of any pay-for-performance initiative in Medicare.
- When measuring quality, focusing on misuse and overuse is equally important as underuse.
- To the extent possible, performance measures should incorporate outcomes of care in addition to structure and process measures

- CMS should make meaningful disclosure of performance results to the public, which will reinforce the value of pay-for-performance.
- The health care system will need sufficient health information technology infrastructure to report performance measures. Some providers, particularly solo and small group physician practices and those serving low-income urban and rural areas, may need financial assistance to purchase needed systems, software, training and related services.
- The Medicare program should consider expanding the proportion of Medicare payment and reimbursement based on performance over time as it implements pay-for-performance.

Pay-for-Performance in Medicare is Needed Now to Improve Quality and Safety:

A landmark 1999 Institute of Medicine (IOM) report estimated that preventable medical errors in hospitals might cause as many as 98,000 deaths annually. Many more people are injured in hospitals and countless more preventable deaths and injuries occur in outpatient settings.

A 2003 RAND study found that patients received only 55 percent of recommended care for fairly common medical conditions for which a broad consensus exists on care standards.

The Dartmouth Atlas of Health Care's most recent findings reveal wide variation in hospital care and outcomes for chronically ill Medicare patients.

Fisher and colleagues (Annals of Internal Medicine, 2003) estimate that up to 30% of Medicare spending may be for excessive and unnecessary care.